Centers for Medicare & Medicaid Services

National Stakeholder Call with CMS Administrator, Chiquita Brooks-LaSure

Tuesday, November 1, 2022

3:00pm-4:00pm ET

Webinar recording:
https://cms.zoomgov.com/rec/share/zHUam0kcNlqqT8ghug1llNSpe8fn4DZn0ULkuSK-EeAfq7kYKE479KuB9iBUrXPu.4iZVEk-Q0kpCNtsV *Passcode: ^AVgr7@^*

Bruce Alexander: Hello and welcome to all of the over 1600 folks on the recording right now. My name is Bruce Alexander and I am the Director of the CMS Office of Communications. Thank you so much for joining us today for our fourth Centers for Medicare and Medicaid Services National Stakeholders Call. I'm going to walk you through today's agenda and then turn things over to our speakers. But before I do that, I have a few housekeeping items. This call is being recorded. Also, while members of the press are welcome to attend the call, please note that all press and media questions should be submitted using your media inquiries form which may be found at CMS.gov/newsroom/media-inquiries. That's CMS.gov/newsroom/media-inquiries. We will not be accepting live questions during the call however, we did solicit questions beforehand and we will answer a few of those today. Everyone should be able to see today's agenda on their screen. We have a full agenda that includes the CMS Administrator, Chiquita Brooks-LaSure and her leadership team. Each providing an update on CMS recent accomplishments, and how our progress on our cross-cutting initiatives is advancing the CMS strategic plan. These presentations will be followed by a question and answer session, where we will address some of the questions we solicited from many of you. And with that, I'll turn it over to our leader and Administrator, Chiquita Brooks-LaSure. Administrator?

Chiquita Brooks-LaSure: Thank you, Bruce. It is a pleasure, always, to meet with this group. And it is really hard for me to believe that it is November already. This year has gone so quickly. As you know, here at CMS it is open enrollment season. But before we look ahead to one of our favorite times of the year, I'd like to highlight a few of the amazing milestones from the last few months. This summer marked the 57th anniversary of the Medicare and Medicaid programs. It was only 57 years ago, in 1965, that many of our country's hospitals remained segregated. It wasn't until Medicare and Medicaid were established, tying hospital payments to desegregation, that those norms changed. Through the three M's, Medicare, Medicaid and CHIP, and the Marketplace's, CMS and our partners have the leverage to shape the healthcare industry and advance tangible changes that make a meaningful difference in the lives of millions of people. We have been working hard these past few months to pull all of our levers to advance health equity, expand access, engage partners, drive innovation, protect our program sustainability and foster operational excellence. And we continue to work to promote strengthening the safety and the quality of care at health care facilities across the

country. I am especially proud of what we have accomplished over the last few months, working alongside our state partners and Medicaid program to bridge health disparities and ensure that all people can access high-quality health care. Last month we announced groundbreaking demonstration initiatives with Massachusetts and Oregon that advanced health equity in several ways. For example, for the first time ever, children with Medicaid coverage in Oregon will be able to keep their coverage continuously until age six. In Massachusetts, people who are homeless will have 24 months of continuous eligibility for Medicaid. These initiatives also support whole person care by coordinating care and addressing root causes of health concerns including housing insecurity and lack of nutritious food. The innovations in Oregon and Massachusetts, and now also in Arkansas and Arizona, ensure that people can obtain optimal health regardless of circumstances. I am truly excited to see more innovations introduced across the country, breaking down long-standing barriers to health care for underserved communities. Across the three M's, the 150 million people we serve are the focal point for all we do at CMS. We are working every day to achieve better health outcomes by treating the whole person and advancing equity. Putting people at the center of their care improves the healthcare experience and their overall health. At the same time, the whole person approach to care, reduces cost for the entire healthcare system. In August, I was proud to announce that the Medicare Shared Savings Program, through our work with accountable care organizations, saved Medicare almost $2 billion in 2021. These savings underscore a huge gain for the millions of people who are part of an accountable care relationship. Accountable care organizations perform better on several quality measures compared to clinical groups who are not in the program. Whole person care is proving to have better outcomes for people who need care for diabetes, high blood pressure, breast cancer, colorectal cancer, smoking, depression, and more. These are just a few highlights of our work in the past few months. We have speakers from across CMS today who will highlight even more. Before we get to them I just want to mention, just a little bit more about our dual open enrollment seasons. In the marketplaces, we are kicking off the 10th open enrollment today. And I know for so many of you who have been with us over the last 10 years, as you know, I have not been here the whole 10 years, but it's just a thrill to be back here celebrating that we got to the 10th open enrollment. And thanks to the Inflation Reduction Act, which continues the financial assistance introduced by the American Rescue Plan, people can continue to afford high-quality health care coverage in 2023 and beyond. Thanks to the Biden-Harris Administration, they can get help enrolling. In August, we announced nearly 100 million dollars in grant funding to 59 returning navigator organizations for this year's open enrollment period to help people navigate enrollment through marketplace coverage and Medicaid and CHIP. It's our largest navigator funding award ever. And it's in addition to the $59 million we're investing in the Connecting Kids to Coverage program. Connecting Kids to Coverage grantees will provide Medicaid enrollment and renewal assistance to children and their families and for the first time ever, to expectant parents to promote, improve maternal and infant health outcomes. This year's Medicare open enrollment, going from now through December 7, brings long-awaited cost savings on vaccines and prescription drugs. Starting next year, in 2023, recommended adult vaccines, including the shingles vaccine, will be free of charge for people with Medicare prescription drug coverage. And in 2023, people will get their covered insulin with

no deductible and they will pay no more than $35 for a month's supply of each covered insulin prescription. We are encouraging people to ensure that their plan covers the insulin products they need to maximize their savings in 2023. And for all 64 million people with Medicare, Medicare open enrollment is the time each year where they can review their health care and prescription drug coverage and make changes. As you know, there are two main ways to get Medicare coverage, original, or traditional Medicare and Medicare Advantage. There are differences between the two that are so important to understand when you're choosing your coverage. We are continuing to encourage people to call 1-800-Medicare or a state health insurance assistance program for help comparing these options. We also continue to emphasize that the Medicare savings programs, which are run by the states, can help provide additional assistance for cost sharing for people who are enrolled in Medicare. Your work to meet people where they live, where they work and play, adds a human touch to the enrollment process. And those of you who are engaged in these efforts, will help hard to reach and historically underserved communities get the health coverage they need to stay safe, feel healthy and supported, and to have the peace of mind that health care coverage brings. I am now going to turn it over to our several senior leaders today, who are from across CMS and have more updates to share. And so much of our work comes across the various centers and offices, so it is really my pleasure to turn it over first to Dr. Meena Seshamani who will talk in more depth about some of our recent accomplishments and our cross-cutting initiatives in the Medicare program. Meena?

Dr. Meena Seshamani: Great. Thank you so much, Administrator. It is wonderful to be here with all of you. Again, my name is Dr. Meena Seshamani and I am the CMS Deputy Administrator and Director for the Center for Medicare. I'd like to take this opportunity to highlight some of the work that we have been doing in the Center of Medicare, and where we need your help and partnership to further our collective goals to advance health equity, expand access to coverage and care, drive innovation for high quality whole person care and protect our programs affordability and sustainability. First, we are hitting the ground running on the implementation of the Inflation Reduction Act. This new law offers financial stability for seniors and for people with disabilities, reducing the monthly cost of insulin and providing recommended vaccines at no out-of-pocket cost beginning in 2023. It provides peace of mind, stabilizing Medicare premiums beginning in 2024 for Part D and lasting through 2030. It caps out of pocket drug costs for part D enrollees at two thousand dollars and provides the option of paying in monthly installments beginning in 2025. And it empowers Medicare to finally negotiate directly with drug manufacturers for the price of certain high spending brand-name part B and D drugs ensuring that people with Medicare get the best deal possible on treatments they deserve, and ensuring innovative drugs are available when Americans need them. Collectively, the Inflation Reduction Act furthers our equity, access, innovation, and sustainability goals. We appreciate your help in making sure people know the benefits that will come from implementation of the new law. One concrete way that you can help is through Medicare open enrollment. As the administrator mentioned, Medicare open enrollment is going on now through December 7. It's so important for all of us to support people as they decide what option works best for them, especially now with the new benefits to come from the Inflation Reduction Act. In addition to telling people about 1-800 Medicare, you can direct people to the

updated Medicare plan finder on Medicare.gov, so that people can compare options for health and drug coverage which may change from year to year. If it is someone's first time enrolling in Medicare coverage, they can go to Medicare.gov and click on "getting started with Medicare" or call 1-800 Medicare. Now circling back around to people with Medicare who take insulin. As I mentioned, starting January 1, 2023, out-of-pocket costs for insulin in Part D will be capped at $35 per month supply per covered insulin product. And again, this is why it is so important to connect people to call, 1-800 Medicare. Plans cannot charge people for more than $35 for one-month supply of each Medicare Part D covered insulin they take and they can't charge a deductible for that insulin. Now sticking with the theme of Medicare enrollment, we also just released a final rule that marks the most significant changes to Medicare enrollment rules in over a decade. They simplify and expand Medicare enrollment opportunities which reduces gaps in coverage and promotes accessibility to vital life-saving drugs. For example, this is the first time that special enrollment periods will be available for individuals, particularly those who are vulnerable, who were unable to enroll before due to exceptional conditions, such as people who were affected by disaster, who were formerly incarcerated and for those who lose Medicaid eligibility. Collectively, these policies support CMS's goals to advance health equity and keep people with Medicare at the center of our program. These new policies take effect on January 1, 2023. And there are even more ways we've been keeping people with Medicare at the center of what we do. As the Administrator mentioned, we have a program called the Medicare Shared Savings Program with accountable care organizations - groups of doctors, hospitals and other providers who joined together voluntarily to give coordinated, high quality care to people with Medicare. Providers in this program consistently have higher quality ratings than other providers, and the program has saved more than 1.6 billion dollars in 2021 alone. We are inspired by such successes, and that is why we're proposing numerous enhancements to the program. For example, proposing to give money upfront to small providers in rural and underserved areas, so that they can make the investments they need to engage and provide this whole person high-quality care. We're also proposing to reward excellent care delivered to underserved populations through this program, and some other adjustments as well, particularly in rural and underserved communities. Because overall, we see this is a path forward with all of you to continue to grow this program so that we can achieve our goal of having 100% of people in traditional Medicare in an accountable care relationship with their provider by 2030. Now it's clear with all that we want to do, that we can't do this important work alone. That's why we recently released a Request For Information on Medicare Advantage which we see as one of many conversations on the next steps in Medicare Advantage policymaking. We asked for input on ways to achieve the agency's vision so that all parts of Medicare are working towards a future where people with Medicare receive more equitable, high-quality, and person-centered care that's affordable and sustainable. We received a robust response to this RFI and we are committed to creating additional opportunities to engage all of you and the public, and drive innovation in ways that best serve people with Medicare. I want to thank you all again for all you're doing for the 64 million people in the Medicare program. I'll now turn it over to Ben Walker, Director of Open Enrollment, Federally Facilitated Marketplace, for the Center for Consumer Information and Insurance Oversight update. Thanks.

Ben Walker: Thanks very much Meena. I am so excited to be here with all of you today on the first day of open enrollment for Marketplace coverage for 2023. As you know, open enrollment for the Federally Facilitated Marketplace platform, which is serving 33 states this year, will be running through January 15 on healthcare.gov. Once again, we are really emphasizing for folks that while we are open until January 15, the last day for most consumers to pick a plan for coverage effective January 1 is December 15. You'll see that December 15th date a lot over the next six weeks in our marketing and communications. We had a great start to open enrollment this morning and we're looking forward to another successful open enrollment based on a continued strong collaboration with state-based Marketplaces, state regulators, qualified health plan issuers, and key stakeholders like you. I want to talk briefly about three areas that are really going to be important in helping us build upon last year's record-breaking numbers. First, as you know, one of the keys to our success last year was the enhanced subsidies available under the American Rescue Plan, which helped millions across the county see an average of 50% savings on their premiums over the last 18 months. As a result of the Inflation Reduction Act, these enhanced subsidies will continue to be in place through 2025. Which means that we can say that going into this year's open enrollment, four out of five consumers who enroll will find a plan on the Marketplaces for a premium of less than 10 dollars per month after tax credits. Now on top of that, we are also thrilled that the IRS recently finalized regulations to fix what has been referred to as the family glitch. Many of you are familiar with this and you worked many years on this issue. To summarize, under the prior rule, if employer coverage for an employee only, not their family members, was deemed affordable, then everyone in their family who is offered that employer coverage is ineligible for tax credits to purchase Marketplace coverage, which left an estimated 5.1 million family members of employee individuals unable to gain access to the tax credits that help make the Marketplace coverage affordable. Under the new rule, affordability for family members is calculated instead based on how much it would actually cost for their employer coverage. This change is already in place at healthcare.gov for consumers who are shopping today. Third, I want you to know that we are continuing to focus on outreach and enrollment assistance with a substantial multichannel outreach campaign where we utilize television, radio, digital, and direct consumer messaging delivered in multiple languages as well as the recent award of nearly $100 million in funding for 59 navigator organizations which the Administrator mentioned earlier. We are also continuing to work closely with agencies, brokers, certified application counselors and community partners to help consumers get one-on-one assistance when and how they need it. While open enrollment is certainly top of mind today, I do also want to make sure that you know we're continuing to work collaboratively to prepare for the eventual end of the COVID-19 public health emergency with the focus towards mitigating coverage lost wherever possible by helping individuals smoothly transition from Medicaid to the Marketplaces or other coverage. We know that it is a key focus area for many of you, and we'll look forward to sharing more details on our thoughts in that area soon. Most importantly, I want to thank all of you for the hard work you have put in to help make the marketplaces successful so far, and for everything you'll do in the coming weeks to help consumers get high quality affordable health insurance. At this point, I will turn over to Dr. Lee Fleisher, CMS Chief Medical Officer and Director for the Center of Clinical Standards and Quality.

Dr. Lee Fleisher: Thank you so much Ben. CMS continues to advance our national quality strategy. We have a clear focus and goal on creating a more equitable, safe, high quality and outcome-based health-care. To promoting patient safety throughout the health-care care system, we are looking at ways to prevent harm or death from health care errors to engaging with patients and providers and using all of our levers. We have been actively listening to and engaging with health-care providers. We have heard clearly the concerns and challenges many of you are facing, particularly around staffing, burnout, and work force turnover. We know these issues impact patient safety. We are focused on building a strong culture of safety and look forward to working together to get back to the basics to improve safety across the health care system. We are building on key priorities to advance health care equity by better measuring health care quality disparities and improving the safety and quality of maternity care. Thank you for all the thoughtful comments you have provided on the maternal health request for information. We continue to review them for future policy directions. Unfortunately, the United States has the highest maternal mortality among industrialized nations with demonstrated inequities. To support the goal of improved maternal care, we have finalized two new maternal health measures. Cesarean birth, which assesses the rate of deliveries in the hospital by c-section, and severe obstetric complications, which assess the proportion of severe obstetrics complications that occur during the delivery hospitalization. We are also finalizing a new publicly recorded birthing friendly designation. This designation focuses on maternity care so that consumers can easily identify hospitals that provide high-quality maternity care. The designation will be rolled out for the first time in the fall of 2023 using data from the program's maternal morbidity structural measure which hospitals are already reporting on and requires hospitals to attest whether they are participating in a state or national prenatal quality improvement collaborative and implementing the patient safety practices as part of these quality improvement initiatives. In the Medicare hospital payment final rule, we adopted quality measures on addressing health care disparities. The first measure, hospital commitment to health equity, will ask hospitals questions regarding their commitment to health equity, specifically if they have a strategic plan, if they have collected and analyzed data, if they participate in quality improvement activities related to equity, and if hospital leadership are engaged in these activities. We are also finalizing two complimentary measures focused on screening of patients for certain health-related social needs. The first of these measures, screening for social drivers of health, assesses the proportion of patients screened for the following five social drivers: food insecurity, housing instability, transportation needs, difficulty with utilities, and interpersonal safety. The second related measure, screened positive rate for social drivers of health, will require hospitals to report the total number of screened patients who indicate they have one or more of these health-related social needs. In April, CMS released our behavior health strategy which addresses a number of elements including access to treatment services for substance use disorder, mental health services, crisis intervention and pain care. We are engaged in key activities in support of the recently released HHS roadmap for behavioral health integration which advances the present strategy to address our national mental health crisis. In February 2022, the president announced a comprehensive set of reforms aimed at improving the safety and quality of care within the nation's nursing homes. One is to ensure that

every nursing home provides a sufficient number of staff who are adequately trained to provide high quality care. We are currently engaged in a new research study to determine the minimum staffing requirements needed in these facilities. In addition to reviewing comments received in conducting a new study, CMS will consider feedback from stakeholder listening sessions to inform the proposed rulemaking on many staffing requirements in nursing homes, which we plan to issue in Spring 2023. Finally, as a physician, I encourage each of you to make an appointment to get the newly updated bivalent COVID-19 vaccine and also your flu shot, especially as we inch closer to the holidays. The updated vaccine protects against the original and two Omicron COVID-19 strains. Should you test positive with COVID-19, remember there are treatments available and you should talk to your health care provider to determine which treatment option is best for you. Please encourage your friends, coworkers, family members to also get their updated COVID-19 vaccine and also remind them of the available treatments. Thank you for your time today. I will now turn it over to Dan Tsai, CMS Deputy Administrator and Director of the Center for Medicaid and CHIP services. Dan.

Dan Tsai: Thanks Lee. Good afternoon folks. There is a lot happening in Medicaid which I'm sure folks feel I hope in an exciting way. We also want to acknowledge how much is happening. Our daily discussions with our state partners really just give a sense of how much is happening across the Medicaid program as we think about preparations for unwinding from the public health emergency and many other policy and operational initiatives underway. I will touch on four areas from a Medicaid and CHIP standpoint. Thanks to all of you for a lot of your day-to-day engagement with us regardless of whether you are on the state side, provider side, advocate side, plan side or others. First, coverage and access --that's one of our main themes and goals for Medicaid and CHIP. A few notable things over the past quarter, we put out a proposed rule streamlining eligibility and enrollment for Medicaid and CHIP. It has some really exciting, we think, policies and operational pieces. It touches on kids, and kids' eligibility. It touches on how to bring parity in many of the streamlined application and renewal things that were afforded through the Affordable Care Act in certain parts of the Medicaid population and extended that to the rest of the Medicaid population. It carries through many of the things we've learned from working side-by-side in preparation for the end of the PHE with states on various strategies to really help people maintain coverage to the greatest extent possible when folks hit that 12 month renewal for Medicaid which we see a lot of people lose coverage, not because they lose eligibility, but for other reasons. We are excited about that. Comments close on that I think in six days. If you haven't sent your comments in, we are looking forward to them. That's one piece. Also, certainly from PHE unwinding where we've been engaged for the better part of a year and a half with all of the other community states, that work continues. We continue to spend a very significant amount of time with our state counterparts pairing more guidance documents that will continue to be a major focus for us. We are excited about the number of states taking up with partner coverage. We have a lot in the works from a policy standpoint on insuring and maintaining a floor for access in both fee-for-service and managed care. Much more will come on that. Second area, behavioral health and kids health. Those of you, if you are on this call, I assume you read every document we put out. I hope so. If not, FYI. We've put out, in part through an executive order from the President, in part through the safer communities, the

Bipartisan Safer Communities Act, we put out a substantive guidance around kids behavioral health affirming that behavioral health treatment, screening, care across the entire country is an entitlement right for all kids under the EPSDT for at work and really put out a set of best practices we have seen across states, most of which do not require any new Medicaid authority, but really are things that states and our counterparts can take advantage of. We are eager to partner with our state's counterparts on that. A fair amount of work that we both put out will be services and maximizing school-based Medicaid along with substantial stakeholder engagement with folks in the educational and local school district community around how to reduce some of the administrative barriers to school districts taking up school-based Medicaid. Some other things, including a medically complex health model for kids, and starting to approve and get applications from states around mobile crisis models, which we're very excited about. I think, folks are aware we continue to work together around trying to expand exciting things like CCBHC together with our SAMHSA colleagues and through the Bipartisan Safer Communities Act quite a bit of technical assistance, funding, guidance, other work again on school-based Medicaid. Third, you heard the Administrator mention some of the groundbreaking 1115 demonstrations that we have put out over the past few months. Those approval letters and the STCs, the detailed terms and conditions behind, again they make excellent bed reading if you ever want. Many of those documents outline substantive policy direction, groundbreaking policy direction at a federal level, if we are thinking about health related social needs around housing, nutritional access in a different way on the Medicaid standpoint, continuous eligibility for kids and adults in different ways including zero through six in Oregon which we are really excited about. Workforce grants and other things that help expand access and a range of other pieces as well including Medicaid budget neutrality with an 1115 demonstrations. Finally, there is a range of other really important work. Folks have recently commented, I think, on another proposed rule around certain mandatory quality core set measures that we're really excited about at Medicaid. We have 10 or 11 states with section 1115 demonstrations before us on justice involved and Medicaid coverage within carceral settings, and a lot of work with the community around the HCBS, home and community-based services setting tool and how to make sure that some of the basic rights afforded to individuals in receiving HCBS services really are affirmed across the country. That is a little bit of a snapshot. There is a lot happening. We are grateful for engagement and partnership. All of this stuff requires rolling up our sleeves together so we are looking forward to that continually. I will now turn it to Liz Fowler, who is the Director of the CMS Innovation Center. Thank you.

Dr. Elizabeth Fowler: Thanks Dan. You are a hard act to follow. Thanks to everyone on this call for your continued partnership in working to improve the health and healthcare for people served by our programs. Your commitment and dedication are what really drives us forward. I am really pleased to have the opportunity to provide an update from the Innovation Center. Since the last national stakeholder call, we have had many developments, hit some milestones and made several announcements. I'll just highlight two here. First, we announced the 2023 participants in the Medicare Advantage Value-Based Insurance Design model, sometimes called the VBID model. Through this model, CMS is testing a broad array of health plan innovations designed to enhance the quality of care for people enrolled in Medicare Advantage as well as

reducing costs for enrollees and the overall Medicare program. A key feature of the model is the focus on equity and the ability to target reductions in cost sharing and health related supplemental benefits to those with specific health conditions or who receive low income subsidies. For example, plans can provide meal delivery services, and programs transportation for nonmedical needs, access to virtual community-based programs, counseling or companion care to address social isolation, and assistance with rental support for enrollees who receive low income subsidies. We are really excited about the reach and potential impact the program will have in 2023 in helping people enrolled in Medicare Advantage meet a wide range of health-related social needs and better address health outcomes, equity, and quality of care. Second, we announced an extension of the bundle payments for the care improvement advanced model, sometimes called the BPCI Advanced Model, for two additional years. It will now extend through 2024 and 2025. We are also making changes to the model based on stakeholder feedback and interest from participants who remain in the model test. CMS Innovation Center models are test and modifications are sometimes needed in order to meet the goals of reduced spending and improved quality. We believe that the BPCIA Advanced Model, and we remain committed to care redesign. Stepping back from specific model tests to the bigger picture, we are nearing the one-year mark of the publication of our strategic refresh which promotes and advances priorities outlined in CMS 's six strategic pillars. To recognize this milestone, the Innovation Center is publishing a one-year strategy update report which we hope to release in the very near future. The report provides an update on accomplishments in implementing the strategy over the last year and provides a roadmap of where we are heading across each of our five strategic objectives. The report will also provide more detail on how we propose to measure progress on the goals that we set. Finally, I'm going to put a plug in for the Health Care Payment Learning and Action Network meeting November 9th and 10th. CMS Administrator, Chiquita Brooks-LaSure, will give a keynote address and the Innovation Center will provide more details about the specialty strategy we're releasing this fall. The LAN Summit is open to the public. If you're interested in joining us, go to LANsummit.org to register. At the heart of all of our work is people and ensuring that they experience care differently. For the Innovation Center, this means driving a more person-centered health care system where individual perspectives are reflected in all of our models. I'll stop there and express my appreciation again for our partners on this journey towards a health system that works better for all people. With that, I am going to turn it over to Dr. LaShawn McIver, who is Director of the CMS Office of Minority Health. Dr. McIver?

Dr. LaShawn McIver: Thank you Dr. Fowler and hello everyone. As you know, my name is Dr. LaShawn McIver and I'm the Director of the CMS Office of Minority Health. It is my sincere privilege to join you today and provide a brief update since our last call. As many of you know, the CMS Office of Minority Health's mission is to lead the advancement and integration of health equity in the development, evaluation and implementation of CMS's policies, programs, and partnerships. For CMS, equity is defined as the attainment of the highest level of health for all people where everyone has a fair and just opportunity to obtain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language or other factors that affect access to care and

health outcomes. On our last call, we discussed how CMS is taking an integrated, action oriented, data-driven and stakeholder informed approach to advancing health equity. CMS OMH plays an important role in guiding these efforts across CMS programs. To do this, we work across the agency's health equity advisors to help guide, counsel and offer detailed technical expertise across all of our programs and policy areas. In addition, by providing executive level leadership and accountability, we are fostering an environment that advances health equity by increasing collaboration and integration across the agency and framing CMS's approach to operationalizing equity in partnership with all of our communities, individuals and stakeholders. What are some of the significant strides we've made in the third quarter of this year? Throughout 2022, we have worked to move the needle on CMS's strategic pillar to advance health equity using the five priorities in our CMS framework for health equity as a guide. Since most of our partners in the field don't work with just one CMS program, much of our work focuses on aligning our approach to health equity as an agency. Data is one example of this. The collection and analysis of stratified demographic and SDOH data are called out in this first priority of the CMS framework for health equity and a major area of focus our stakeholders have asked us to take action on. We have been working hard across the agency and coordinating across programs to expand collection and stratification of data within each of our programs. We look forward to sharing a larger update with you on our next call together. CMS is ensuring its health equity approach is responsive to the unique needs of our stakeholders through active engagement efforts. We place high importance on hearing from our partners during calls like this and much smaller ones on a regular basis. Trusted community partners are essential to health equity and we're doing the work to connect our partners and our policies and our programs. For example, this summer we held multiple round tables covering topics such as access to data and its standardization, gaps in coverage, as well as barriers of specific populations and how CMS can prioritize addressing them and finally, reactions to the CMS strategic plan and framework for health equity. CMS OMH additionally held six listening sessions on sexual orientation and gender identity data collection with external individuals and organizations representing stakeholders from diverse groups such as providers, advocates, state and federal health officials and insurance brokers. We heard recommendations for collecting SOGI data in existing CMS forms, data systems and programs. The information will be shared with policy leaders across the agency. We have also been to many conferences and roundtables and listening sessions, such as our recently held listening session at the 2022 National Tribal Health conference, where we hosted a listening session to present on our health equity priorities and to receive important tribal input. I'd also like to share that we recently awarded our grantees for the Minority Research Grant Program, or MRGP. This program helps to support researchers and eligible minority-serving institutions who are investigating or addressing health care disparities affecting racial and ethnic minorities, LGBTQ+ persons, persons with disabilities, persons who live in rural areas and persons otherwise adversely affected by persistent poverty or inequality. You can learn more information about our grantees and their projects on our Minority Research Grant Program webpage. In closing, thank you again for the opportunity to share just some of the incredible work underway to advance equity. I look forward to our continued partnership on this important journey. With that, I will now turn it over to Dara Corrigan, our Deputy Administrator and Director of the Center for Program

Integrity. Thank you.

Dara Corrigan: Thank you so much for the introduction. It is a pleasure to be here today to talk to you about recent updates from the Center for Program Integrity. Our mission is simple here. It is to prevent, detect and combat fraud, waste and abuse in Medicare, Medicaid, CHIP and the Marketplace. I would like to focus on two areas today that I thought might be interesting to you as we are hopefully coming out of the pandemic. During the pandemic, in the Public Health Emergency, CMS used its emergency waiver and regulatory authorities to ensure flexibility so that providers and suppliers could respond rapidly to the PHE. For example, within CPI, we paused some medical reviews and review activities early in the PHE. When we restarted, we reduced the number of reviews and gave providers additional time to respond to requests for additional documentation. It is our hope, and we believe, that these flexibilities helped providers and suppliers focus on responding to the needs of their patients rather than on documentation request. We want to minimize disruption following the end of the PHE and we know that people have raised concerns with us about what our approach will be coming out of the PHE. Most waivers and flexibilities will end at the conclusion of the PHE and some have been terminated already. For example, during the PHE, we exercised enforcement discretion in several areas. We have not enforced clinical indications for coverage for certain durable medical equipment (DME) items. This enforcement discretion will end at the conclusion of the PHE. Because some of the DME items, provided during the PHE, are rental items we know that suppliers will want to know what happens to those items post-PHE. Many other questions have been asked about items that have been received during the PHE, what will happen afterwards and how we will protect beneficiaries who received certain items during the PHE. We expect to release, (prior to the end of the PHE) guidance on how those waivers will be addressed at the end of the PHE. We've listened to concerns and we respond as quickly as we possibly can because we know it's important to you, and it's important for us, to be very clear. We coordinate with our colleagues across CMS, including the Center of Medicare and CCSQ, to ensure that when we are making program integrity decisions, they're made with policy officials and coverage officials that come to the right solution for our beneficiaries and individuals who are a part of our program. We hope that in the meantime, CMS, we encourage health-care providers to prepare and to begin moving forward to reestablish previous health and safety standards and billing practices. One of our particular achievements over the last few months that we were very proud of, is really moving to provide transparency on nursing home ownership. To enhance the overall nursing home safety and quality and to ensure compliance with the Biden-Harris Administration Executive Order on Promoting Competition, CMS continues to make more data publicly available than ever before, to improve transparency for researchers, regulators and loved ones. We think by having transparency, it leads to more people thinking about policy issues and we have better input and we can make better decisions. On September 26, 2022, CMS released new ownership data for all skilled nursing facilities enrolled in Medicare. This information posted now includes detailed information on the ownership of approximately 15,000 nursing homes certified as Medicare Skilled Nursing Facility (SNF). The expanded data elements include information about each organizational owner, such as whether it is a holding company or a consulting firm. This release is an expansion on what we released in April of this year where we,

for the first time, publicly released data on mergers, acquisitions, consolidations and changes of ownership from 2016-2022 for hospitals and nursing homes enrolled in Medicare. This dataset gives researchers, as well as Federal and State agencies, the ability to discover common owners of nursing homes to better analyze quality of care across facilities with common ownership. We believe that having access to data is the first step and we look forward to really critically looking at this data and performing analysis that will help us look for answers and solutions to the problems that we find. The new nursing home ownership data is accessible to consumers through a link in the ownership section of Care Compare on the Medicare.gov website. This dataset will be updated on a monthly basis on data.CMS.gov. I really thank you for your time today. I look forward to our next update. Right now, I will like to turn it back to Bruce Alexander, who will moderate the question and answer session. Bruce?

Bruce Alexander: Thank you Dara and to all of our speakers today. I think they did a fantastic job delivering the message. As I mentioned earlier, we solicited questions prior to the call and we will walk through those now. Our first question is for Dr. LaShawn McIver. The CMS Office of Minority Health identified data collection as an important area that CMS is addressing to advance health equity. Can you give examples of other areas you are prioritizing in the Health Equity Framework?

Dr. LaShawn McIver: Thank you for that question Bruce. While I briefly spoke about the priority area of expanding the collection and stratification of data across our programs, the CMS health equity framework outlines five priorities that inform our efforts for the next 10 years. Some of the other priority areas within the framework include CMS' commitment to supporting health care providers, plans and organizations that ensure individuals and families receive the highest quality care and services. For example, CMS is considering ways to encourage safety net provider participation in accountable care organizations and value-based care and ways to structure our programs to support providers in identifying and addressing social risk factors and social determinants of health as they provide care and coverage. Additionally, CMS has a powerful role in strengthening efforts across the health care system to improve access to culturally and linguistically tailored, health literate care and services for our increasingly diverse population. We are working towards ensuring CMS materials are in multiple languages and at appropriate literacy levels and that navigators and certified application counselors are available to help consumers enroll in the right health care plans to meet their financial and health care needs. Additionally, we have recently updated our Coverage to Care (C2C) initiative, which helps consumers understand their health coverage and connect to primary care and preventive services that are right for them. These materials include a total of eight languages, totaling over 100 now updated resources. Lastly, accessibility is essential to obtaining necessary and appropriate care and services, particularly for people with disabilities. We are committed to ensuring that individuals and families can access health care services when and where they need them in a comfortable and respectful way. Those are some of the other priorities. Thank you.

Bruce Alexander: Thank you for your response Dr. McIver. The next question is for Dr. Lee

Fleisher and Mr. Dan Tsai. On April 5, 2022, the President signed the "Executive Order on Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage" which directed agencies to identify and examine ways to continue to expand the availability of affordable health coverage, including "policies or practices that strengthen benefits and improve access to healthcare providers." How does CMS envision incorporating policies to improve access to healthcare providers as a part of the agency efforts to advance equity? Secondly, will this include the prior initiative to identify Medicare or Medicaid conditions of participation or coverage that have a negative effect on health equity?

Dr. Lee Fleisher: Thank you so much for the question Bruce. On the Medicare side, CCSQ is looking at all of our levers including the conditions of participation, the quality measurement, the quality improvement and coverage, many of which we outlined earlier in our updates related to the Quality Strategy. In our National Coverage Decision on Aduhelm, we emphasized the importance of including a diverse population of patients that reflect the disease incidence in the Medicare population in any studies providing evidence to make coverage decisions. We are continuing to imbed this approach into our coverage decisions and using lessons learned appropriately. We are employing multiple strategies in our Quality measurement program including providing confidential stratified reports on readmission measures to the hospitals and including proposing, as I described earlier, the first social determinants of health measures. We are also going to be spending time listening and learning from healthcare providers who have made great progress in the advancing equity within their practices, particularly as it relates to wellness visits. We are looking to learn how using information such as housing, transportation, education-level, etc. all can help create a better quality of care for individual patients. Dan, do you have thoughts or additions from a Medicaid standpoint?

Dan Tsai: I think access is a part of the core, one of the most challenging pieces to always figure out and even define. Many of you submitted, I mean we got hundreds, thousands of comments on the access RFI. We are actively trying to work on how do we define a floor for even how to measure access, a timeliness to access to core services like primary care and behavioral health. Those are things we would expect to really try to codify in some way as a framework for ensuring that folks across the country really have some minimum level of access to care. Finally, I think some of our, even our 1115 demonstrations, we've tried to weave in, along with the health related social needs, focus on measuring and increasing rates, core base rates, to primary care, behavioral health providers, OB/GYN services. Those things all go together. I'm sure we are going to figure out some things. I'm sure we are going to have a lot of opportunity to keeping working together in cases.

Bruce Alexander: Thank you Dan. The next question is for Administrator Chiquita Brooks-LaSure. Administrator, as Dan mentioned, CMS recently approved several groundbreaking Medicaid demonstration projects. Can you speak to how these state demonstrations strengthen Medicaid and support our goals?

Chiquita Brooks-LaSure: Thanks Bruce. As we really have been talking about, we at CMS are just tremendously excited about working with our partners and one of those key partners really

are states. Over the last couple of years, we've just seen states do so much. With these last initiatives that we were talking about today, Arizona, Arkansas, Oregon and Massachusetts, we are seeing a next level in terms of really addressing a lot of the social needs, so whether it's short-term housing and nutrition, and also making sure we have continuous coverage for children. We are really excited about the work that states are doing with us.

Bruce Alexander: Thank you so much Administrator. Our next question is for Dr. Meena Seshamani. Can you tell me more about the implementation of the caps on rising drug prices that went into effect October 1 of this year? When will people see relief?

Dr. Meena Seshamani: Absolutely Bruce. Thank you for that question. The Inflation Reduction Act establishes new Medicare inflation drug rebates. What this means is that in general, under the Inflation Reduction Act, drug manufacturers will have to pay a rebate to Medicare if they raise their drug prices for a part B rebatable drug or part D rebatable drug at a rate that is faster than the rate of inflation. These inflation rebates are already used in other health programs, such as Veterans Affairs, TriCare, Indian Health Service, and Medicaid. This new law extends similar provisions to benefit people with Medicare coverage. In the Medicare part D inflation rebate program, October 1 is the start of the first 12-month period for which drug manufacturers will be required to pay rebates to Medicare if their prices for certain part D drugs increase faster than the rate of inflation over the 12-month period. The part D inflation rebates for the 12-month periods begin October 1, 2022 to October 1, 2023, and then will be invoiced by December 31, 2025. For Medicare part B drugs, January 1 is the start of the first quarter for which drug manufacturers will be required to pay rebates to Medicare if their prices for certain part B drugs increase faster than the rate of inflation. These part B inflation rebates for quarters in 2023 and 2024 must be invoiced by September 30, 2025.

Bruce Alexander: Thank you so much for that answer Dr. Seshamani. I have another question for you. What 10 drugs will the Secretary select for negotiation? Why is that number so small?

Dr. Meena Seshamani: Consistent with the requirements of the Inflation Reduction Act, the Secretary will select the first 10 drugs for negotiation from a list of 50 qualifying single source drugs with the highest Medicare part D expenditures and without any generic or biosimilar competition. Seven years must have passed since FDA approval for a drug and 11 years must have passed since FDA licensure for a biological product for those products to be eligible as a qualifying single source drug for inclusion on the list of negotiation-eligible drugs. Some drugs will be excluded from this list such as certain orphan drugs which are designated as a drug for only one rare disease or condition and for which the drug's only approved indication is for such disease or condition. Drugs with Medicare parts D and B expenditures that are less than 200 million, and certain small biotech drugs.

Bruce Alexander: Thank you again for that response. Our final question is for Administrator Chiquita Brooks-LaSure. Continual feedback is important to CMS as we move forward in implementing the law. What should public input, specifically patient input, look like during

the price negotiations process?

Chiquita Brooks-LaSure: As you've mentioned, one of our core pillars, when we think about our CMS work, is how we engage stakeholders and we are committed to having a very open process in terms of public input. We have already started to meet with stakeholders, including patient groups, as we think about how we move forward to implement the Inflation Reduction Act, and as Dr. Seshamani and I mentioned, we are just really thrilled to be in the position of being able to implement these changes for people. More to come. We are thinking about how to make sure that there is active stakeholder engagement for our programs.

Bruce Alexander: Thank you so much, Administrator. Ladies and gentlemen, that wraps up our question and answer session. I want to thank all of our speakers today and thank everyone that joined us from your busy schedules to be part of this national stakeholder's call. We are conducting these calls quarterly so please keep an eye out for the invitation to our next call for next quarter. With that, I would like to turn it over to our Administrator, Chiquita Brooks-LaSure for closing comments.

Chiquita Brooks-LaSure: Thank you all. Thank you all again for joining us. We find it just tremendous to be able to connect with our stakeholders and very much appreciate you taking the time out to speak with us. Thank you.