

Centers for Medicare and Medicaid Services

National Stakeholder Call with CMS Administrator Chiquita Brooks-LaSure

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Beth Link: Hello, and welcome, and particularly to the over 2300 folks that are on the line, right now, my name is Beth Link. I am a Senior Advisor for External Affairs in the Office of the Administrator at CMS. We thank you all for joining us today. This is the third in our series of national stakeholder calls we've held, and we'll talk a little bit about today's agenda and then turn everything over to our wonderful speakers. I did want to note a few housekeeping items before we get started, as you see this call is being recorded. I do want to note that while members of the press are welcome to attend this call, please note that all press and media questions should be submitted using our media inquiries form which may be found at cms.gov forward slash newsroom forward slash media dash inquiries. We will not be accepting live questions during this call. However, we thank you for sending your questions in to us ahead of time and we're going to be answering some of those questions today. Everyone should be able to see the agenda up on the screen. We have a full agenda full of updates from across our Centers and Offices here at CMS today. And you're going to hear first and foremost from our leader, the CMS Administrator Chiquita Brooks-LaSure, and then from leadership from across the Centers and Offices here at CMS that are going to provide updates on recent actions that the Agency has taken, as well as our progress across our cross-cutting initiatives to support care and quality for the more than 150 million people who are served by CMS programs. We are also excited to have a guest speaker here today from the Department of Health and Human Services Substance Abuse and Mental Health Services Administration, also known as SAMHSA, to talk about the new 988 Suicide and Crisis Lifeline. These presentations will be followed by a brief question and answer session as I previewed already and we'll answer some of the questions that folks submitted. So with that, I will now turn the call over to our leader and Administrator Chiquita Brooks-LaSure.

CMS Administrator Chiquita Brooks-LaSure: Thank you so much Beth and thank you everyone who has joined us this afternoon or this morning. I have, over the last couple of months, been able to travel more and really be on the ground with so many of you, and I was just thinking about this meeting, and how much I really appreciate the opportunity to talk to you all -- the stakeholders, because, as you know, we at CMS are responsible now for overseeing an incredible breadth of issues across our Medicare, Medicaid and CHIP, and Marketplace coverage. But it is you who deliver care directly to the people that we serve, and so we really want to make sure that we are doing what we can to communicate the incredible work across the Department, across the government, and particularly at this Agency to make sure that you're well informed of all of the initiatives that we have underway. So I'm really looking forward to the opportunity for you all to hear from leadership across the Agency. We really have tried over the Biden-Harris administration to

be really clear in saying what our objectives are and it's been a little over a year, where we unveiled the six pillars which really were meant to help guide our work. And again, it's all work that we need to do in partnership with all of you. This has not been an easy time, we all know that, but I continue to believe that it represents an opportunity for all of us to really drive health equity and by that we mean really ensuring that everyone in this country has a fair and just opportunity to really live their best lives, regardless of the characteristics that might define them when you look at each person and by where they're born in this country. And so we've been very focused in everything we do at CMS across our programs to make sure that health equity is at the forefront of our policy and operational decisions. There's no place that that is more key than in our maternal health crisis and it's really been an incredible opportunity to work with the Vice President, who has really made this as a "whole of government" approach really, as you know, outlining the maternal health blueprint. CMS is working with all of you across the country to make sure that we are expanding coverage for people postpartum so the 12 months, which are such a vulnerable time as those of us who have had children know just trying to make sure that you have the care that your new baby needs, is just a key part of making sure we are addressing this critical issue. We're using all of our levers and want to continue to partner with all of you to make sure that we address this crisis. As you know, we have been in the forefront of making sure that we are providing that through you, of course. Ensuring that everyone has the right to emergency care. Last week, through letters of our partners, the Secretary and I have reinforced this notion that the federal requirements under EMTALA, or the Emergency Medical Treatment and Labor Act, are in effect. Pregnant women have the full rights and protections through EMTALA regardless of what state laws may be in terms of abortion coverage. We want to make sure that people across our country are getting access to the care that the need, when they are in these incredibly vulnerable states where their health is in jeopardy. We also want to make sure that families know about birthing-friendly hospitals so that is an initiative we have been rolling out and look forward to ensuring high standards of care at all of the facilities across the country. Another example of health equity that we are working with all of you on is expanding access to home and community-based services. The American Rescue Plan has given new opportunities to expand services and access to strengthen the home and community-based service provider workforce, impacting social determinants of health and improving quality. We are seeing states across the nation use those dollars in ways to make sure that people are getting care in the most appropriate setting. For example, in Washington state, they are using those dollars to expand whole of person care for people experiencing homelessness and behavioral health conditions. In Illinois, they are using those dollars to expand services to children with behavioral health needs. Through these programs and others across the country, we are creating easier paths to health care and advancing health equity across the care system. Those are a few of the places we have seen improvement in health equity. We continue to be excited about the open enrollment period that we had over these last couple of months and nationwide. We had 14.5 million people who signed up for coverage, bringing our programs across the board to record levels of covering at CMS -- over 150 million people. When we were in the process of doing that outreach, last year and at the beginning of this year, we were able to target and reach historically underserved communities through increased efforts, particularly through our navigator programs, as well as our media outreach. We have been able to see not only is the uninsured rate at all-time lows, but enrollment for Black and Hispanic people has increased

significantly. More than 26% for Hispanics and 35% for Blacks. Finally, but of course not least, we are continuing to do incredible work in our Medicare program. Our team is always on such a process in terms of our annual and fiscal rules. One of those, the Physician Fee Rule, which just came out, has expanded access to behavioral health which we hear so much about and you will hear more from our colleague at SAMHSA in just a moment -- as well as hearing about dental services and cancer screenings, which as you know is a Presidential priority with reinvigorating the Cancer Moonshot. These are just a couple of the really exciting areas of focus for our agency. We've been able to meet stakeholders and have had over 250 events over the last year. We want to continue in a variety of forums to make sure we are hearing from you and incorporating your perspectives into our policymaking. With that, I'm going to, as Beth said, turn it over to our special guest, we are thrilled to partner across the Department and make sure we are integrated, and there is nothing I think that is more on top of minds in terms of all of us then addressing our mental health crisis. I'm going to turn it over to the Acting Deputy Assistant Secretary for SAMHSA, Tom Coderre, who will talk about the 988 code.

Tom Coderre: Thank you so much Administrator Brooks-LaSure and to my friends at CMS for the opportunity to join this important stakeholder call today. Many of you know that SAMHSA's mission is to reduce the impact of mental illness and substance use in America's communities. And our newest initiative, as the Administrator just said, is 988. You may have heard over the past few days that "hope" has a new number, 988. This weekend marked our country's transition from the National Suicide Prevention Lifeline to a new three digit, easy to remember number, 988. The transition offers an unprecedented opportunity to strengthen and transform crisis care in our country. But 988 is more than just a number. Too many people are experiencing suicidal crisis or other types of mental health-related distress without the support and the care that they need. So, 988 will serve as a universal entry point so that no matter where you live, you can reach a trained crisis counselor who can help. The goal of 988 is providing 24/7 access to mental health crisis counseling – and most importantly, to save lives. To reach the lifeline, people can call 988 of course but they can also text 988 or they can chat. We know many young people today love chatting. At 988lifeline.org, they can do it at any time of the day or night and, over time, the vision for 988 is to have additional crisis services available in communities across the country, similar to how emergency medical services work. There really is hope with 988. The lifeline has worked for many years and now 988 will do the same, helping thousands of people overcome crisis situations every day. It is similar to another popular three-digit number, 911. We want people to know someone can be there to help when they are in crisis. Our goal is sustainable, long-term change. Remember though, it has taken over five decades for 911 and emergency medical services to grow and expand in our country. So it will take time to build this system as well. We know we don't have five decades to grow this system because people's lives depend on it. With 988, we are poised for faster transformation of our country's crisis care system. We have come a long way in strengthening and expanding the existing lifeline. 988 will continue to grow and evolve in the coming months and years. President Biden believes we must address the mental health crisis, which is why he has secured historic funding for crisis centers. The lifeline has historically been underfunded and under-resourced, but the Biden-Harris administration has increased federal investments 18-fold, from just \$24 million last

year to \$432 million this year for this national priority. \$282 million of that was to scale up crisis centers with \$105 million directed to states and territories. This funding began to reach centers back in March and is reaching local centers in April. We just received new investments from the Bipartisan Safer Communities Act, which recently became law -- \$150 million additional dollars to go toward 988. The long-term success of 988 rests heavily on support from states and territories. To help everyone communicate clearly about 988, SAMHSA has created an online 988 partner toolkit. It has downloadable files, frequently asked questions, fact sheets in English and Spanish and lots more. And last but not least, we have been involved in extensive efforts to push out important messaging about crisis center workforce needs, linking to SAMHSA's jobs page through partner email distribution lists and amplifying through multiple social media platforms. You can visit [SAMHSA.GOV/988](https://www.samhsa.gov/988) to access these resources and learn more about this exciting new initiative. The success of 988 depends heavily on the willingness of state, territorial and local leaders to make additional investments in shoring up their crisis systems. So we must work together. Transformation of this scale is never easy. We're going to work together with you because the federal government can't do this alone. We need and appreciate the partnership our friends at CMS have offered us, and we appreciate the opportunity to join the call today. Thanks so much.

Jon Blum: Thank you, Tom for your comments. We have a slide to put up and we wanted to echo the comments that were shared previously, that here at CMS, we think about our work, we are focused on ensuring that we have a cross-cutting focus. We don't think about Medicare, Medicaid and Marketplace by themselves, but think about one common strategy for cross-cutting work. The second core principle we have is when we're thinking about policy, we are also tying very carefully to how we think about the operations. So there is never any break or disconnect between how we think about policy and how we think about our core operations. For COVID response, we think about it this way. Our approach for the agency is to ensure the work is coordinated, that we are focused on how we operate but also how we think about the future, not just the current pandemic, but how we plan and think about what could happen next. And we really want to think about three points here. First is what we're doing right now. The Public Health Emergency (PHE) is still in effect, just extended for 90 more days through October 6. That is the current state we are in. The first point is, we are in current states maintaining the PHE that will go through the next 90 days. The second point is to cover the current focus. We think about CMS' roll with the COVID response, we have four core purposes. The first is to do everything that we can to extend and maintain health insurance coverage that will keep people safer and healthier. Second is provide stable coverage and reimbursement for testing vaccines and treatments. Third is to issue new provider regulations and guidance to keep the health care system, keep patients, and workers safe to make sure that we keep health-care facilities open to all patients. And fourth is to promote and support waivers through federal law and state programs that give more flexibility to the health care system to ensure that it can serve people better, can serve people more flexibly, and to keep the health systems safe and open for all patients. Those are our four areas now that we are focused on to ensure that we can do everything we can to keep patients safe, healthy, and secure during the current COVID pandemic. But we are also thinking about the future and want to make sure we're doing everything we can to help support and help stakeholders plan for the world that we are going

to enter next. We are absolutely committed to giving full notice, 60 days, for planning and preparation. PHE does come to a close but we are also focused on four areas right now to ensure that we can help support states, providers through the next phase, whatever it is. First is doing everything we can, we have teams dedicated throughout the country to help states prepare for carefully staged Medicaid pre-determinations and make sure we are connecting dots to other programs to ensure we can preserve coverage through various means. We want to make sure we build upon the gains we have seen through the coverage expansions. Second is, at some point, reimbursement for vaccines, treatments and testing will shift to Medicare, Medicaid and private insurance. We want to think about the transition very carefully and give ample notice to payers and providers for when that transition will occur. Third is, we plan to issue new regulations to help providers prepare, plan for whatever comes down the pike. We want to think about new regulations that would help hospitals, providers, help prepare for this next phase to our lives. And fourth, for those waivers that are in place today, for us to go through a careful process and a deliberate process to decide what to keep, what to sunset, and which waivers could get turned on down the road if certain conditions get met. We want to make sure that whatever we do, we are doing it in a carefully planned, coordinated way throughout the Agency and to make sure that we are communicating well, giving ample notice, 60 days minimum for whatever happens once the PHE comes to a close. We welcome suggestions and feedback and thoughts for how we can focus on what happens next once the COVID PHE comes to a close. With that we will turn to my colleagues to go through their updates. I think LaShawn is next.

Dr. LaShawn McIver: Hello everyone. My name is Dr. LaShawn McIver and I am the Director of the CMS Office of Minority Health. It is my sincere privilege to join you today to provide an 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 policies, programs, and partnerships. Our vision is that all those served by CMS have achieved their highest level of health and well-being and we have eliminated disparities in health care quality and access. So what is the CMS approach to advancing equity? 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. We are 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 by providing executive level leadership and accountability. We are fostering an environment that advances equity by increasing collaboration and integration across the agency and framing CMS' approach to operationalizing equity in partnership with all of our communities, individuals and stakeholders. One way we are doing this across the enterprise is through the leadership of and participation in the Administrator's cross-cutting initiatives. There are initiatives on a host of topics where health equity is being advanced, including elevating stakeholder voices, behavioral health, maternity care, and more. One I have a privilege of co-leading is the rural health cross-cutting initiative. In this, we are working across CMS' programs to promote access to high-quality, equitable care for

all people served by our programs in rural and frontier communities, tribal nations, and the U.S. territories. By engaging with our stakeholders including providers, quality improvement organizations, and those with lived experience, we are insuring our approach is responsive to their unique needs. What are some significant strides we have made in the second part of the year? Through the first half of 2022, we have worked to move the needle on CMS' strategic pillar to advance health equity using the five priorities in our CMS framework for health equity as a guide. To do this, we work across the Agency as health equity advisors to help guide, counsel and offer detailed, technical expertise across all of our programs and policy areas. Our staff partnered with policy, data, operations and communication teams across the agency to help our entire CMS workforce operationalize health equity across Medicare, Medicaid, CHIP, and the Marketplace. 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. As we think about alignment and building on successes, we also think about how to strengthen our efforts to move the needle further each day to advance equity and eliminate disparities. Data is one example of this. The collection and analysis of stratified demographic and SDOH data are called out in the first priority of the CMS framework for health equity, and a major area of focus our stakeholders have asked for us to act on. We have been working hard across the agency in coordinating across programs to expand collection and stratification of data within each of our programs, thinking about health equity focused measures, and working to increase the availability of and access to CMS data for researchers and our external partners. I would also like to share that we currently have an open Notice of Funding Opportunity posted for our Minority Research Grant Program, or MRGP, which we encourage you to share. This program helps to support researchers and eligible minority serving institutions who are investigating or addressing health care disparities affecting racial and ethnic minorities, also including Lesbian, Gay, Bisexual, and Transgender and Queer persons, persons with disabilities, persons in rural areas, and persons otherwise adversely affected by poverty or inequality. Thank you again for the opportunity to share some of the incredible work underway to advance equity. I look forward to our continued partnership on this important journey. I will now turn it over to Dara Corrigan, Deputy Administrator and Director of the Center for Program Integrity.

Dara Corrigan: Good afternoon and, and thank you LaShawn, I appreciate the introduction. As LaShawn said I am Dara Corrigan, the Deputy Administrator for the Center for Program Integrity, or CPI. At CPI, our mission is to protect beneficiaries from harm and safeguard taxpayer dollars, while trying to minimize burden on providers and suppliers. Program integrity is embedded in all the work you will hear about today across Centers and it is reflected in CMS' strategic pillar to protect our programs sustainability for future generations. At CPI, we believe that the integrity of the Medicare and Medicaid programs are best supported through continued efforts to promote program transparency. As LaShawn said, data is critical. Transparency gives all of our stakeholders the opportunity to look at data with us and provide different perspectives and analysis so that we can make the best policy decisions. CPI is a gateway to the Medicare program. We oversee the enrollment of every Medicare provider and supplier along with collecting comprehensive data on each enrollee, including ownership data. And I am happy to say that in April of 2022, for the first time, CPI publicly released data on mergers,

acquisitions, consolidations and changes of ownership between 2016 and 2022 for hospitals and nursing homes enrolled in Medicare. This data release provides an opportunity for researchers, our stakeholders, law-enforcement partners, to examine how these mergers, acquisitions, consolidations, and changes of ownership may impact health care costs and quality of care, which directly has an impact on the people we serve. Going forward, we expect to release this data on a quarterly basis. On an individual level, our work in CPI often focuses on protecting beneficiaries from harm. This includes ensuring that beneficiaries receive critically needed medical equipment when they need it and where they need it, particularly during the PHE. We don't want beneficiaries staying in an inpatient setting for a longer period waiting for authorization or having to leave an emergency care facility without necessary durable medical equipment. Over this last quarter, we have worked closely with durable medical equipment suppliers and practitioners to develop procedures to exempt certain orthotics like knee and back braces, furnished as part of emergency care, from the need for prior authorization. We look forward to ensuring with you, that the right balance is struck between beneficiary access and program integrity. Finally, CPI continues to combat Medicare and Medicaid fraud related to telehealth, telemedicine and COVID-related fraud. Over the past two plus years, most providers and suppliers have worked tirelessly to react to the COVID-19 pandemic, but some bad actors have used this as an opportunity to take advantage of federal health programs and to exploit the beneficiaries that we want to protect. In quarter two for example, we worked on several cases involving labs that offered COVID-19 testing to induce patients and beneficiaries to provide their personal identifying information and a saliva or blood sample to them at the same time. They then use that information and the samples to submit false and fraudulent claims to Medicare for unrelated, medically unnecessary and far more expensive tests and services. Our administrative actions related to this fraud, such as payment suspensions or revocations, stopped improper payments and contributed to millions of dollars in cost avoidance and savings. I really appreciate the opportunity to speak to you today about some of our quarter two program integrity accomplishments and efforts. I will now turn you over to Dan Tsai, Deputy Administrator and Director of Center for Medicaid and CHIP Services.

Dan Tsai: Hello, I will echo the Administrator and my colleagues' thanks to all of you across a range of roles for partnering with us to do all we can collectively to ensure we have coverage, access and equitable care for close to 87 million enrollees in Medicaid and CHIP. We know the pace is high, we spent many hours with many folks, maybe not all 3100 on this call, but we engage in significant stakeholder policy discussions so thank you. First, just a few quick things over the past quarter that have gone out of note: 12-month postpartum coverage that the Administrator mentioned. We are up at 16 states with another dozen or so in the wings hopefully to be approved shortly. That will take us to quickly over half of states in the country having expanded 12-month postpartum coverage in Medicaid and CHIP. That is really exciting and we hope to get to as many states as possible. We hope all of you will continue to help support that and we can all guess at what the number will be. Connecting Kids to Coverage and the theme of kid, youth, maternal, and other health – a range of things, I think they are being simultaneously announced today, \$49 million in grants to a range of community-based and other entities to advance coverage -- with some new avenues for how we thought about that this year that we are excited about. Home and

community-based services, which is a big priority for us at Medicaid, we have worked together with the community around a range of things we have been putting forward in the near term around affirming coverage in the community and our HCBS settings, as well as extending the timeframe available for this significantly enhanced funding for HCBS services as part of the American Rescue Plan. We have recently put out a Center Informational Bulletin on managed care oversight and other tools that are important for us collectively, given 70 to 80% of our enrollees are in some sort of managed care plan at this time. In parallel, there has been a lot happening policy wise and I will hit on a few of those. Behavioral health, youth mental health and the related, folks have seen we are out there indicating we will be releasing guidance in the near future, affirming the specific role of mental health services within EPSDT, very specific requirements for services and coverage for kids, as well as ways to advance and expand access to school-based coverage, important from an equity standpoint and some of the youth mental health crises we are facing at the moment and a clear administration priority. Second, related to that, we are excited about the many opportunities in partnership with our SAMHSA colleagues and others across CMS and the Department for the bipartisan Safer Communities Act, where there are a fair number of things from the Medicaid standpoint. We will be supporting, accelerating and amplifying some of those things I mentioned before on youth mental health, EPSDT services, school-based Medicaid and some other exciting pieces. Third, many of you know that we have a substantial push on access. Access to coverage and to services within the Medicaid program. It involves a fair amount of policy and other stakeholder listening and other discussions on how to measure and set a floor on timely access to services for all Medicaid beneficiaries across the country, how to think about race and funding for the workforce and we have received about 7000 comments in a recent request for information on access that we have been processing. Fourth, a significant amount of work on 1115 demonstrations, both actions we have taken in partnership and also some important affirmations in various states, as well as a fair amount of work, which there has been much said about for various 1115 demonstrations before us. Things like continuous eligibility for kids and adults in a way that extends beyond a 12-month period. It is exciting for us as an Agency to contemplate, as well as what is the role of Medicaid in really addressing some of the social determinants and health-related social needs to promote equity and whole person care with the right constraints. Finally, I would be remiss if I did not mention that the unjust challenges we know our beneficiaries are facing in the wake of the Dobbs decision. Per the President's Executive Order, and the Administrator and what we have in the Department, we are working across CMS and the Department to protect and expand access to the full range of reproductive health care services with every lever at our disposal. A very important point to note. We thank you for the engagement and the many hours many of you have spent with us and with that I will turn it over to Dr. Ellen Montz, who is the Deputy Administrator and Director for the Center for Consumer Information and Insurance Oversight.

Dr. Ellen Montz: Thanks, and hello to our partners across the nation. It is fantastic to be with you here today. I wanted to focus on two areas today as it relates to updates from CCIIO. First is the work we are doing in partnership with Dan and his team, but also across CMS, across the Department and indeed across the Administration on our work to prepare for the recently extended, as John mentioned, public health emergency unwinding and as

it relates to one of our strong priorities in our cross-cutting work. As I mentioned, we are laser focused on planning for successful coverage transition. So where I sit for folks is when the public health emergency does expire, for folks that are no longer eligible for Medicaid or CHIP who want to make sure they wind up in a coverage position, whether in the Marketplace, employer-sponsored coverage, Medicare, whatever. We are focused on ensuring that folks do wind up in Marketplace coverage where eligible. We take every extension of the public health emergency as an opportunity to ensure that we are better prepared and better equipped for its eventual end. I want to highlight three areas where we are focused, many of these areas you are engaged with us and I thank you for that. First, we are examining a variety of improvements to the federal Marketplace policies and our systems in order to streamline that consumer experience and make it easier for an individual to transition out of Medicaid and CHIP, if they are no longer eligible, to Marketplace coverage. Second, with my colleagues in our Office of Communications, we are planning an aggressive outreach and enrollment campaign for folks who are no longer eligible in order to get them to know that they do have access to affordable quality coverage on the Marketplace. We understand, and as you have seen from this Administration and our previous open enrollment investments as well as from our special enrollment periods, that we recognize that consumers do need assistance with enrolling and getting connected to care, particularly potentially consumers that have had Medicaid or CHIP coverage for a while and are newly potentially applying for private commercial insurance for the first time. To that end, we continue to make investments into our navigator and other assistance personnel, and we plan for them to maintain a critical, physical and virtual presence in communities across the United States to help consumers understand basic concepts and rights related to health insurance coverage and provide them that enrollment assistance to work with individuals one-on-one to ensure that they wind up in an affordable quality coverage situation. Third, we are focused on leveraging the interactions, communication systems that you all, our partners have existing, to help make these transitions successful when the public health emergency does end. Bottom line is that we have a strong track record at CMS with navigating unprecedented circumstances, and our close collaboration with states, consumer advocates, health plans, navigator assistance, agents and brokers, department of insurance, providers and many others are going to help us preserve these connections to coverage by ensuring that folks have that help necessary to get them transitioned when eligible. The other item I want to focus on today, similarly what Dan ended with, as you know too well, a woman's ability to control her reproductive health is more important than ever, and that includes from, where I sit, ensuring that individuals have access to contraceptive coverage without cost-sharing as afforded under the Affordable Care Act. Since 2010, the ACA has made preventive health services affordable and accessible for all Americans. On the Monday immediately following the Supreme Court decision in *Dobbs versus Jackson*, we along with the Department of Labor and Treasury published an open letter to private health plans and issuers, reminding them of their long-standing obligations under the ACA related to contraceptive coverage. Our letter reiterated the obligations under federal law for group health plans and health insurance issuers to cover all FDA approved, cleared or granted contraceptive products without cost-sharing. It also reminded them that this coverage must include clinical services such as patient education and counseling needed for the provision of the contraceptive product or service. The requirements under the Affordable

care Act are quite clear, but it highlights continued reports of noncompliance and outlines the Department's expectation of compliance, emphasizing our full commitment to enforcement. After that letter was published, we then met with plans and issuers to direct them to take immediate corrective action in cases where they need to shore up their requirements under the ACA. This letter is one piece of CMS' and HHS' ongoing comprehensive action plan to protect reproductive health care. In closing, I want to thank all of you, our stakeholders, for your continued engagement in the initiatives I have highlighted today and the many others you will hear about. I will now turn it over to Dr. Doug Jacobs to provide some remarks from the Center for Medicare.

Dr. Douglas Jacobs: Thank you. It is a pleasure to be with you all and I would like to take this opportunity to highlight some of the work the Center for Medicare has accomplished just recently. On July 7, CMS released a Proposed Physician Fee Schedule Rule. It included important changes advancing accountable care, promoting equity, and expanding access to behavioral health. First, I want to highlight the parts of the rule focusing on the Medicare Shared Savings Program. The Medicare Shared Savings Program is the largest accountable care program in the country, serving more than 11 million people with Medicare and including more than 500,000 participating providers. In the proposed rule, there are changes in the program that if finalized, would represent the biggest changes since the inception of the program more than 10 years ago. Building on the CMS Innovation Center's successful ACO Investment Model, CMS is proposing to incorporate advanced investment payments to certain new Medicare Savings Program ACO's that could be used to address Medicare beneficiaries' social needs. This is one of the first times Traditional Medicare payments would be permitted to address the social determinants of health, and is expected to be an opportunity for providers in rural and other underserved areas to make investments needed to become an ACO and succeed in the program. Dr. Fowler will also comment on this program in her remarks. CMS is proposing that smaller ACOs have more time to transition to downside risk, further helping to grow participation in rural and underserved communities. CMS is also proposing a health equity adjustment to an ACO's quality performance score to reward excellent care delivered to underserved populations. This proposal represents one of the first that would promote equity in a value-based care program by rewarding high-quality care delivered to underserved populations. Finally, CMS is proposing benchmark adjustments to encourage more ACOs to participate and succeed, which would help achieve the goal of having all people with Traditional Medicare in an accountable care relationship with a healthcare provider by 2030. Next, I want to remark on some of the proposals in the Physician Fee Schedule that would promote access to behavioral health care, which is a core priority for the Biden Administration. To help address the acute shortage of behavioral health practitioners, the agency is proposing to allow licensed professional counselors, marriage and family therapists, and other types of behavioral health practitioners to provide behavioral health services under general (rather than direct) supervision. Practically speaking, this means that these behavioral health practitioners would be able to provide services without a doctor or nurse practitioner physically on site, expanding access to behavioral health services like counseling and cognitive behavioral therapy in additional communities, particularly rural or underserved communities where care can be hard to find. Additionally, CMS is proposing to pay for clinical psychologists and licensed clinical

social workers to provide integrated behavior health services as part of a patient's primary care team, because it can be easier for a person to get behavioral health care like psychotherapy when the care is coordinated through their primary care provider. These are just a small sample of some of the highly impactful proposals in the Physician Fee Schedule -- please take a look and remember to submit comments before the comment period closes on September 6. Finally, I wanted to highlight that the Outpatient Prospective Payment System (OPPS) rule was proposed last week on July 15. It includes proposals to establish payment for Rural Emergency Hospitals, which goes along with the conditions of participation that Dr. Fleisher will discuss in his remarks. To advance health equity and improve access to care in rural areas, CMS is broadly proposing to cover all outpatient department services as Rural Emergency Hospital services. CMS is proposing a higher payment rate, when services are furnished by rural emergency hospitals. And Rural Emergency Hospitals will receive the standard rate plus 5% for each additional service provided. This new provider type, effective January 1, 2023, will promote equity and health care for those living in rural areas by facilitating access to needed services. Comments on the Rural PPS Rule are due before September 13 and please note that we really do take these comments into consideration as we think about the best pathway to move forward. So thank you in advance to those of you planning to submit comments. I would like to turn it over to the CMS Deputy Administrator and Director for the Center for Medicare and Medicaid Innovation, Dr. Liz Fowler.

Dr. Liz Fowler: Thank you, Dr. Jacobs and for everyone on the call for making time to listen to the progress we are making at CMS and all of the strategic plan and cross-cutting initiatives going on at the Agency. None of what we do would be possible without this community of stakeholders. We are grateful for the chance to work together to improve the health of all people. I'm really proud of the work the CMS Innovation Center has accomplished since our last call. Last month, we announced the Enhancing Oncology Model to transform care for cancer patients, reduce spending and improve overall quality of care. The model is designed to test how best to place patients with cancer at the center of their care through a team that provides high-value, equitable, evidence-based care. The model's design incorporates many of the lessons CMS learned from the Oncology Care Model as well as feedback from the oncology community. Under the model, participating oncology practices will take on accountability for their patient's healthcare quality and total spending during six-month episodes of care for Medicare patients with certain cancers. The model is built on CMS' vision of eliminating health disparities with requirements to provide patient navigation services, develop a health equity plan and collect patient demographics, as well as provide incentive payments for the provision of enhanced services to patients with higher payment for those duly eligible for Medicare and Medicaid. Following on the remarks by Dr. Jacobs, we are also very enthusiastic about the alignment between the Medicare Shared Savings Program and CMMI ACO models. The July 7 Physician Fee Schedule Proposed Rule that Doug mentioned included advanced investment payments derived from learnings from the Innovation Center's ACO investment model. This is a great example of how our larger ACO strategy where the Innovation Center tests new payment and service delivery models using the "chassis" of the Shared Savings Program. This enables us to harmonize ACO incentives and scale important findings. The Physician Fee Schedule also included requests for information with

direct relation to the Innovation Center's work, including an alternative approach to calculating ACO historical benchmarks, and another seeking input on potential approaches to address the end of the APM incentive payment. We look forward to hearing from this community. The team at the Innovation Center is also hard at work thinking through strategies to improve care in areas like maternal health and specialty care. I will stop there and express my appreciation again for our partners on this journey toward a health system that works better for all people. Now I will turn it over to Dr. Lee Fleisher, our Chief Medical Officer and Director for the Center for Clinical Standards and Quality at CMS.

Dr. Lee Fleisher: Thank you so much, Dr. Fowler. CMS released its National Quality Strategy on April 12, 2022 with the goal of insuring all individuals receive equitable, high quality care. Our strategy promotes high quality by focusing on a person-centered approach and uses lessons learned from the public health emergency to support the creation of a more equitable, safe and outcome-based health-care system for anyone. In May, we shared additional details of our vision for quality in our blog, which can be found on the CMS website. We've had the pleasure of holding a number of listening sessions since June 2022 with federal partners, patients and patient advocates, Medicaid stakeholders, social determinant of health experts, and the general public to learn how we can best structure our programs and policies for optimal success. The information gained from these calls has been invaluable. We have heard from Medicaid partners on the importance of supporting better measures for maternal and mental health. And from patient stakeholders who want to be seen, heard and build a community of trust in others who are pointing to a need for a greater emphasis on safety and building safety measures. We have taken this feedback and turned it into action. We have been developing a core measure set to be used across all CMS components and will continue the work across the entire agency to align our quality initiatives, measures and programs. We will continue to engage with you, our stakeholders, in listening sessions and want to hear from you. We welcome your feedback. You can email us directly at qualitystrategy@cms.hhs.gov. As part of our vision, one of our most significant goals is to promote safety by preventing harm or death from health-care errors as well as collecting this data on hospital safety and currently publicly reporting it. I would also like to mention encouraging findings recently published in the Journal of the American Medical Association article: *Trends in Adverse Event Rates in Hospital Patients, 2010 through 2019*, which found that the rates of patient harm in U.S. hospitals fell significantly between 2010 and 2019. However, as we had previously described in a New England Journal of Medicine article earlier this year, we are concerned about the deterioration on multiple patient safety metrics that have occurred since the beginning of the pandemic. Importantly, the findings of the JAMA report are reminders of the successes that are possible and present a framework to help the health care system pivot away from the extreme challenges of providing top-quality, error-free care during the pandemic to one that embeds patient safety in everything we do. Collecting the right data helps us tell an important story and drive meaningful change, which is why in IPPS we took steps to address health care disparities in the hospital inpatient care and beyond, by proposing three health equity focused measures for adoption in the Hospital Inpatient Quality Reporting Program. In April, we released our behavioral health strategy which addresses a number of elements, including access to treatment services for substance use

disorders, mental health services, crisis intervention, and pain care, some of the topics you heard at the top of the hour. Our goal is to remove barriers to care and services and adopt a data informed approach to evaluate our behavioral health programs and policies in a way that supports a person's whole emotional and mental well-being and promotes person-centered behavioral health care. We propose to establish a special hospital designation for quality maternal care, which would also be publicly recorded on the CMS website. The "Birthing-Friendly" hospital designation would assist consumers in choosing hospitals that had demonstrated a commitment to maternal health by using best practices that advance health care quality, safety and equity for pregnant and postpartum patients. CMS recently announced that an estimated 265,000 Americans annually in 15 states and D.C. have gained access to 12 months of postpartum coverage through Medicaid or CHIP. Finally, CMS has recently proposed a rule allowing small rural hospitals to seek the new health care provider designation that has been mentioned by both Dr. McIver and Dr. Jacobs. This will protect access to vital emergency services, observation care, and additional medical and outpatient services such as maternal care and behavioral health for individuals living in rural communities. We aim to formalize these policies in the Outpatient Prospective Payment System Final Rule later this year. As always, we appreciate all of the comments we have received on our proposals and encourage you to continue a valuable dialogue with us. Thank you for your time today. I would look to turn it back to Beth Lynk.

Beth Lynk: Thank you so much. And as we said at the top, we have lots of updates. We have been busy at CMS and you can hear there is a lot to share. We are nearly at time, but we did receive a number of questions from folks prior to this session. So we are going to take two questions and then we will go to the Administrator for some closing remarks. The first question will be for Administrator Brooks-LaSure. Administrator, as you know over the last two years, the public health emergency has been in effect, clinicians and facilities have had success implementing many of the waivers CMS has issued and while we know some of these waivers have been made permanent, many others would terminate at the end of the PHE. We know the Secretary on Friday extended the public health emergency for another 90 days, but folks want to know how CMS is evaluating waivers to determine which will be made permanent once the PHE is no longer reauthorized and what information can be provided that will assist the agency in these determinations?

CMS Administrator Chiquita Brooks-LaSure: Like you, we are really focused on the public health emergency, particularly around making sure we hold onto coverage. As Jon said earlier in the discussion, we are very focused on trying to give everyone as much lead time in terms of making sure people understand our approach. We have already, as you acknowledge Beth, started making some of the changes permanent, such as particularly around mental health for Medicare beneficiaries and there's flexibility for states when it comes to Medicaid and CHIP, and we continue to evaluate which authorities we have flexibility on and ones that will be ready for the next public health emergency.

Beth Lynk: Thank you, Administrator. I'm going to turn our next question to Dr. Jacobs from Medicare. I just wanted to ask, what steps does CMS plan on taking to promote more stability in Medicare provider payments in order to ensure continued access to high-quality care for our nation's seniors.

Dr. Doug Jacobs: Sustainability is a core pillar of CMS and Medicare because we want to make sure that our programs are around for future generations. In Medicare, as I talked about earlier, the promotion of accountable care relationships actually helps get us there. Over the past five years, the Medicare Shared Savings Program has been estimated to save Medicare over \$6 billion. With some of the changes we have proposed in the Physician Fee Schedule, we can expect additional savings to the Medicare Trust fund, so that Medicare is sustainable for future generations while providing high-quality coordinated care to beneficiaries.

Beth Lynk: Thank you, Dr. Jacobs. We are tight on time and I know we are over time by two minutes, so thank you to folks who submitted questions. We will certainly have time to ask those potentially in a future session. With that, I want to turn it to our Administrator for any closing remarks and we will close the call.

CMS Administrator Chiquita Brooks LaSure: Thanks, Beth. It is always a marvel when we go through these discussions just how much there is to talk about and I'm sorry we did not have more time to answer questions. We will continue to try to get information out for a variety of different opportunities. I hope this session of hearing from leadership across CMS and SAMHSA has been helpful to you and we really look forward to continued discussions. Have a great day.