Centers for Medicare & Medicaid Services
National Stakeholder Call
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JONATHAN BLANAR: Hi, everyone, we're going to give it a minute to let all the participants in and then we'll go ahead and get started. Thank you.

JONATHAN BLANAR: Hello, and welcome to the almost 2,000 people on the webinar right now. My name is Jonathan Blanar and I'm the Acting Deputy Director in the Partner Relations Group in the Office of Communications at CMS. Thank you so much for joining us today for our second Centers for Medicare and Medicaid Services National Stakeholder Call. I'm going to walk through today's agenda and then turn things over to our speakers.

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/media questions should be submitted using our Media Inquiries Form--which may be found at cms.gov/newsroom/mediainquiries. We will not be taking live questions, but we did solicit questions beforehand and we'll answer a few of those today.

Everyone should be able to see today's agenda on their screen. We have a full agenda starting with CMS Administrator, Chiquita Brooks-LaSure and her leadership team reflecting on the extraordinary legacy of Martin Luther King Jr., and we'll be providing an update on the CMS strategic vision and our road map for the year ahead.

Next, CMS senior leadership will review some key 2021 accomplishments, along with some top priorities for 2022. These presentations will be followed by a brief question and answer session where we will address some questions we solicited recently from many of you.

With that, I'll turn it over to our leader, and Administrator, Chiquita Brooks-LaSure. Administrator?

CHIQUITA BROOKS-LASURE: Hello, I'm Chiquita Brooks-LaSure, and I have the privilege of being the Administrator of the Centers for Medicare and Medicaid Services. It's really a pleasure to speak with you today. Our goal is to conduct these national stakeholder calls on a quarterly basis, to provide a forum for us to share updates, and hear your perspective on the important policy issues facing us.

As we commemorate the extraordinary life and legacy of Reverend Dr. Martin Luther King Jr., I'm reminded of his vision for our country, his hope for the future, and the words he used to inspire so many people. But in the harsh light of a pandemic that has cut short thousands of lives, some words stand out. Dr. King once said “Of all of the forms of inequality, injustice in health care is the most shocking and inhumane.” I wish that more progress had been made since he first uttered those words, but unfortunately the numbers tell us a sad and familiar tale of inequitable access to care.

As the first African-American woman to lead CMS, I care deeply about advancing health equity in everything we do. My goal is to ensure that our programs are operating to reduce these disparities and inequities. Here at CMS, we define health equity 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 circumstances.

Pursuing health equity is a key goal of the Biden/Harris administration as a whole. To advance this goal at CMS, we are making the question "How are we promoting health equity?" the first question we ask. It is a critical lens that we use to evaluate all of our policy and implementation decisions.

To achieve our vision, everything we do at CMS will be aligned with one or more strategic pillars:

1. To advance health equity by addressing all health disparities that underlie our health system.
2. To continue to build on the Affordable Care Act, and expand access to coverage through all three M's: The Marketplace, Medicaid and CHIP, and Medicare.
3. To engage all of our partners and the communities we serve.
4. To drive innovation to promote equity and quality.
5. To protect our programs' future sustainability.
6. To foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS's operations.

Six pillars, six aspirations, six ways of advancing, even just a little, the dream of Dr. Martin Luther King. And his dream is, ultimately, the American dream--that everyone will have a fair and just opportunity to attain their optimal health.

And those guiding principles have driven us to take positive action, by:

- Protecting people from surprise medical billing through the No Surprises Act, which went into effect on January 1st. And we're working to ensure that people know their new rights under the law.
- Promoting last year's COVID special enrollment period and this year's annual open enrollment period, to help millions of people find quality and affordable coverage. Today, over 14 million people are now enrolled in the marketplace--an all-time high!
- Rolling back restrictions to Medicaid coverage, including prohibiting harmful Medicaid work requirements, and ensuring that Medicaid is available as a safety net, particularly during this pandemic.
- Expanding availability of home and community-based services.
- Proposing steps to close equity gaps, by focusing on improving the experience of people with Medicare who are battling end-stage renal disease.
- Making permanent telehealth services for behavioral health care in Medicare.
- Continuing to respond to the ongoing and ever-evolving challenges of the COVID pandemic, by being responsive to the needs of patients and providers, and promoting the critical importance of the COVID-19 vaccine, including the booster dose, for the people we serve.

Though we have more work to do, our Administration is committed to expanding access to affordable, high-quality care, and building a more equitable health care system--and I believe we will achieve this goal.

Before I wrap up, let me introduce six key members of the CMS leadership team who you already know, but who I'm just so thrilled to share the screen with. They all work very hard every day to do their part to ensure that millions of people have access to affordable, quality health care, and I really appreciate that they've come to speak with you today.

- Jon Blum, our Principal Deputy Administrator and Chief Operating Officer
- Dr. Meena Seshamani, Deputy Administrator and Director of the Center for Medicare
- Dr. Liz Fowler, Deputy Administrator and Director of the Center for Medicare and Medicaid Innovations
- Dr. Ellen Montz, Deputy Administrator and Director for the Center for Consumer Information and Insurance Oversight
- Dan Tsai, Deputy Administrator and Director of the Center for Medicare and CHIP Services
- Dara Corrigan, Deputy Administrator and Director for the Center of Program Integrity, and
- Dr. Lee Fleischer, Chief Medical Officer and Director of the Centers for Clinical Standards and Quality.

Thank you. I'd like to turn it over to Jon who will discuss where we are headed in 2022.

JONATHAN BLUM: Thank you, Chiquita. I have a slide to put up. And one of the things that we really want to talk about today, in addition to our policy agenda, is to share how we plan to work, to operate throughout the year. And we see really as important as our policy agenda, is the work that we do day-to-day--the operations for how we work, how we plan, and how we engage throughout the year. Let's put the slide up, please.

One of our core beliefs is that we can have a strong impact to help patients by having really “best in class” operations. In addition to our policy ideas, we believe that how we operate, how we work, and how we partner can have as much impact as the overall policy thoughts that we have. We have five operating principles we really want to follow this year, to ensure that we're clear, that we're transparent.

The first being that all six policy areas that we have within CMS will put forward clear visions that describe the work, that describe how we want to operate, and really crucially important—that stakeholders can participate in this overall work.

Second, we want to make sure that we are critically focused on how we think about the overall customer experience. We see ourselves as being the largest payer for health care in the country; and we care deeply for how customers, patients, families and communities really see the programs that we operate.

Third, is that we will always rely on data science to ensure that we have the best decisions going forward. We want to share that data widely to ensure that stakeholders see the same data that CMS sees, to ensure, again, that we are being fully transparent.

Fourth, is we want to make sure that we're taking the 'waste' out. That means making sure that our rules and regulations are really simple. It means making sure contracting processes follow the best principles to ensure that every dollar taxpayers give us is used wisely.

And fifth, to ensure that we do everything we can to be strong partners, to be strong stewards, and to ensure that we're doing everything possible to help respond, mitigate and really solve the overall current pandemic.

These five principles will guide us. We want to make sure they're clear. But really, to ensure they're helping to put forward the best policy agenda going forward. So with that we'll turn it over to Meena to talk about the first vision going forward.

MEENA SESHAMANI: Great. Thank you, Jon. Good afternoon to all of you. And for those of you in the western time zones, good morning. I'm Dr. Meena Seshamani, the Director for the Center for Medicare. Medicare, as you know, is a bedrock of our nation's health care system. More than 63 million Americans are enrolled in Medicare, and it accounts for one out of every five health care dollars. So when you make a change in Medicare, it really wields influence on the health care system writ large--and that's an opportunity, and a responsibility that I take seriously.

Last week in the Health Affairs journal, I laid out the vision for Medicare with our Administrator, Chiquita Brooks-LaSure, and with the Director of the Innovation Center, Liz Fowler. This vision mirrors what the Administrator just spoke about--wanting to advance health equity; expand access to affordable coverage and care; drive high-quality person-centered care; and promote affordability and sustainability of the Medicare trust funds.

I'd like to take just a few minutes to walk you through our strategies and plans. First, advancing health equity. As the Administrator mentioned, equity will be the first thing that we think about. We must look at everything we do through the lens of health equity. Because when the system doesn't work, it's those individuals with conflicts, health and social needs who fall through the cracks. I know this personally, as a physician and as a woman of color, where I've had firsthand experience working with patients who don't speak English, and who don't have a family member who can make multiple phone calls and follow up on paperwork for them. And, ultimately, who get lost in the shuffle.

So recently, we announced a proposal, for example, to ensure that materials developed for people with Medicare are easy to understand, and available in more languages. Again, so that our overall operations work for everyone.

Along this same line, advancing health equity requires building the capacity of health care organizations and the workforce to reduce disparities. Following congressional action, in December we announced that we are funding more medical residency positions in hospitals, serving rural and underserved communities--one of the largest increases in partially Medicare-funded residency slots in a decade. Having providers train in the very communities that need them most means that these providers will be better equipped to treat these disadvantaged communities. And, these providers will also be more likely to practice there, after finishing their training. Meaning that these communities will benefit for years to come.

While equity is one of the pillars of our vision, it's important to remember that equity is also driven by each and every pillar of our vision. So, for example, we want to drive high quality person-centered care--

aligning and growing holistic care models with a goal of having 100% of people in original Medicare in a care relationship that's accountable for quality and total cost of care by 2030.

This has a direct impact on equity. When providers work together to address a person's needs across the spectrum of their experiences, you can address fundamental disparities that have impacted health.

We also want to improve access to coverage and care. We are prioritizing increasing enrollment in the Medicare savings program, which provides financial support for those of lower income and resources. Approximately 10.3 million people are enrolled in these programs as of December, 2021, a more than 800,000 increase from December 2020. And for 2022, we will continue to make it easier for people to enroll in Medicare and eliminate any delays in coverage.

And finally, we want to be responsible stewards of the Medicare program. We are increasing transparency regarding hospital prices, and how Medicare dollars are spent in Medicare Advantage. We will continue to improve payment accuracy and address fraud, waste, and abuse.

Now all of this work has a common theme. We must work with our partners to put people with Medicare at the center of all that we do. I sincerely thank all of you for everything that you do, and for those of you on the front lines during this pandemic, as well. And we want to hear your ideas. We want to work together to drive meaningful change in the health care system.

And so with that, I'd like to turn it over to CMS Deputy Administrator and Director for the Center for Medicare and Medicaid Innovation, Dr. Liz Fowler. Liz?

LIZ FOWLER: Thank you, Dr. Seshamani and Administrator Brooks-LaSure. It's a pleasure to be here today and speak with everyone who joined us. I echo Dr. Seshamani's thanks to all those who are at the front lines of delivering care during a pandemic. We owe you a debt of gratitude.

The CMS Innovations Center had a busy year in 2021. As part of our effort to define a new strategy for the future, we looked back at the past ten years to understand what we learned and what we could have done better.

In October, we released a White Paper detailing five objectives for obtaining a health system that achieves equitable outcomes through high-quality, affordable, patient-centered care. These five objectives, which are in line with the pillars the Administrator laid out for the agency and consistent with the vision that Dr. Seshamani just described, include the following:

- First, to drive accountable care. I'm sure you're hearing a theme now--which to us, means increasing the number of people with a physician (or practice) who is responsible for coordinating, managing and improving care.
- Advancing health equity. Again, another central focus of our work, as well as the Agency's work. We're committed to embedding equity into every aspect of our innovation models.
- Supporting innovation. This means doing more to provide actionable data and disseminate best practices to participants in our models.
- We also want our models to do more to address affordability, and we'll be looking at strategies that target health care prices or reduce unnecessary care.
- And finally, partnering to achieve system transformation. This means that we will be placing a premium on multi-payer alignment.

Going into 2022, we remain committed to getting feedback and input for our new direction. An initial listening session in the new year will focus on patients and how the Innovation Center should be centering patients in everything we do. We'll share more information on our website in the weeks to come. This is one step we're taking to think more about what patients want from the health care system and from their doctors and providers--and ensuring that we align our goals with what matters to patients.

In addition to getting feedback, we're using the strategy to re-examine and realign the CMS Innovation Center model portfolio. As part of our renewed approach, we're creating a more streamlined model portfolio. We're committed to having a more cohesive articulation of how all of the CMMI models fit together. You can expect us to use this new framework and set of principles as we prioritize potential new models, and have opportunities to improve our existing models. Thanks again for being here. I hope you'll consider joining us at a 2022 listening session to share your feedback.

And with that I'm going to turn it over to Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight to talk about their highlights from last year and upcoming priorities.

ELLEN MONTZ: Great. Thank you, Liz. And good afternoon everyone. It is absolutely wonderful to be here with you today. I do want to start with a few highlights from 2021 that I believe really embody our foundational pillars and priorities at CMS. And the first is our Marketplaces. Noting that some state-based marketplaces are indeed still open. But in the wee hours of Sunday morning this past weekend, healthcare.gov did wrap up this year's open enrollment season.

And, what I am here to tell you is that we've got a historic enrollment to show for the historic affordability on the Marketplace and our historic outreach and enrollment efforts. As you can tell, I'm incredibly excited by how meaningful, what this means to our members.

And while we don't have official data on the entirety of open enrollment, I did want to highlight that we've previously released that this year's open enrollment has outpaced last year's open enrollment by over 20% in the 33 states using healthcare.gov. We also announced this past week, as the Administrator highlighted when she opened the call, that we have enrollment nationwide of more than 14.2 million people that have signed up for coverage in open enrollment. This includes, excitingly, over 10 million on healthcare.gov–-a number we exceeded late last week and are incredibly proud of.

We have much to attribute the success to, and it speaks to our future endeavors in growing this market. First, obviously, we have the success of the special enrollment period that ran through August of last year.

Second, as I mentioned, we've had record affordability this year. In this open enrollment, over 90% of our folks are receiving premium tax credits. And, many of them are receiving health insurance coverage, valuable health insurance coverage at zero premium. Third, we have our outreach efforts--including both our increased investment in the number of navigators--quadrupling the number of navigators who are available to assist consumers, and our renewed and increased commitment to outreach and enrollment.

We are particularly proud of the effort in this area, in our outreach and enrollment campaign, and that we not only focused on the raw numbers--but also that we specifically focused on increasing access and

awareness to reach those in traditionally underserved communities. I think our numbers will have a great story to tell here and our numbers will show that concerted effort.

And fourth, I would be remiss if I didn't highlight your dedication in partnership to this effort. I think we all appreciate that the work of connecting folks to coverage is profoundly important and often life-saving. In addition to our record enrollment, we are incredibly proud that on January 1 we launched the critical consumer protections in the No Surprises Act. Beginning on January 1, surprise billing in private insurance is banned for most emergency care, and many instances of nonemergency care where out-of-network care is received at an in-network facility. In addition to a ban on surprise billing, we also launched the consumer protection that allows uninsured and self-pay patients to receive information on their anticipated costs of care from their providers, and an avenue through which individuals can dispute any charges that are significantly higher than quoted. The No Surprises Act offers significant relief to people across the country and reinforces our fundamental belief that no one should go bankrupt from seeking necessary care.

We're making it easier for consumers to know and understand their rights under the law, including what they can do if they received a surprise medical bill. Consumers will not only benefit from these rights, but will also be empowered with the knowledge to address potential violations. Consumers and other stakeholders can access key information on No Surprises, and I encourage everyone to write down our website— www.cms.gov/nosurprises, or call the help desk at 1-800-985-3059 for more information.

As the Administrator also mentioned, CMS is planning additional consumer and stakeholder outreach in this area in the coming months to ensure that consumers know and have access to information on using their new rights and protections.

As we look onward to our 2022 priorities, I'll mention three here. First, is continued implementation of No Surprises. Going live with these consumer protections was just the beginning. Like our health care system, our No Surprises Act is incredibly complex and implementation will be large scale and an ongoing effort. And I look to you all to continue to have our relationships and involvement where we form feedback loops in order to ensure that what we're implementing these provisions, and these protections, in a way that are meaningful to consumers.

Second, we will continue our focus on enrollment. As many of you know, in the coming months, millions of consumers will go through a Medicaid redetermination. And millions will no longer be eligible for Medicaid, but instead be eligible for Marketplace coverage. The good news is that we've got a really great value and great plans to offer folks that are no longer eligible for Medicaid, and we are focused on how best to facilitate coverage transitions for these consumers. Across CMS, we are working very closely together, exploring all possible avenues, to limit avoidable coverage gaps or loss. There is no simple answer here. I call on you for your partnership. In these relationships and our combined efforts that we will help ensure that individuals wind up in the coverage that is right for them.

And finally, we are focused on an equity-driven approach to increasing equality and access to health care on the Marketplace itself. We've got incredible enrollment numbers and we now turn to the work of ensuring that the plans that individuals have deliver on quality and access. With that in mind, last month we released our proposed rule for our plan year 2023--for the Marketplace. The comment period is still open for ten more days, but I will briefly mention a few components of that rule that I do think embody the goal to increase quality and access to health care.

First, we propose standardized plan designs to help make shopping for consumers easier to understand and compare cost plans.

Second, we propose network adequacy rules to ensure consumers have the access to health coverage even when they have that health insurance plan.

Third, we propose to reinstate the prohibition on discrimination based on sexual orientation and gender identity, and also reinstate essential community provider threshold requirements from the Obama administration.

And finally, we propose scaling back a certain pre-enrollment special enrollment period verification requirement in the Marketplace. Here, I highlight a data-driven approach that we're taking to policy. And in these efforts, we took a look at our data and saw a disproportionate impact on these special enrollment pre-verifications by race. To summarize, we examined this data and have now proposed scaling back areas where we think it is detrimental to coverage.

I encourage everyone to take a look and please comment on the proposed rule. And again, I want to say thank you for having me here today, and being able to speak with you all. I look forward to our partnership.

With that, I will turn it over to my colleague Dan Tsai, Deputy Administrator and Director of the Center for Medicaid and CHIP Services.

DANIEL TSAI: Thanks, Ellen. Good morning and/or good afternoon, folks. Thanks for what our colleagues are doing on the frontline around service delivery and care provision, or from colleagues at the state and territory level through Medicaid and CHIP. A few months back, the Administrator and I released a blog that outlined three large policy pillars for Medicaid and CHIP as we move forward with the program. Those three included: First, coverage and access. Second, equity. And third, innovation in full-person care.

Coverage and access involve partnering with as many states as possible to ensure access to Medicaid expansion; to ensure that folks that are eligible for Medicaid maintain eligibility rules and policy and operations; and to ensure that folks maintain their coverage to the greatest extent possible. This effort involves working with states to think about access and care for behavioral health services. It also involves access to home and community-based services for many of our enrollees, how to think about access to networks of providers, and what a floor might look like for Medicaid across the program both in fee-for-service and managed care.

Equity, as the second pillar (as the Administrator has noted), is first and foremost at the center of our policy and operational thinking--not an afterthought. For us, that involves ensuring we're encouraging and working on measurement and baselining where there are disparities, measuring and closing gaps in those disparities, and making very targeted investments and policies that actively advance health equity and reduce disparities at the very forefront.

And third, for innovation in full-person care. This involves, as you heard from Liz at CMMI, partnering together to get advanced value-based care. But it also means thinking about equity as front and center of that and thinking about many of the upstream drivers of health and social determinants of health--as

part of the framework for what we are looking for in care delivery, integration and advancement on the ground.

Let me share just a few highlights of the past year moving forward. First, we would note two states, Oklahoma and Missouri, who have expanded Medicaid within the past year. There has been a range of work ongoing on that, and we are eager, open and here to partner with any other states to think about how best to expand Medicaid services and coverage for populations and individuals that do not have it.

Second, bearing in mind the theme for equity in a broader maternal postpartum health effort at CMS, CMCS put out guidance for Medicaid around 12-month postpartum coverage--of which we had many states take up early 1115 demonstrations; who also indicated an appetite to take up the state plan option for expanding 12-month postpartum coverage for individuals. We're hopeful and eager to partner with as many states as possible to take up that option.

Third, it has been quite an exciting time for home and community-based services. There has been great energy, great investments, and a heck of a lot of work to do going forward. The 10% enhanced funding from the American Rescue has been a large area of focus for us for the states–it's a life-changing amount of funding. We're really looking to partner with states together to make sure those investments are used for immediate needs and for ongoing structural systematic advancements in HCBS access.

Fourth, as the Administrator and I noted in our blog, relatively soon we expect to be laying out some proactive policy priorities around how we approach 1115 administrations that involve both partnership with states and responding to the innovation and ideas at the state and territory level--as well as advancing very clear proactive policy that promotes the objectives of Medicaid and preserves and protects coverage.

You can expect more of that to come, including both very exciting work with a whole range of states around interesting ideas and proposals that we've been able to support. And, as the Administrator noted, taking very specific, thoughtful actions around 1115 demonstration authorities that add the effect of restricting coverage--whether around work requirements or certain premium requirements for coverage above and beyond some of the various statutory and other frameworks that we have. We expect to be working more with folks very intently in that area.

Fifth, on equity and social determinants of health, we anticipate substantial partnership and focus with folks on that in the coming year. I will note some of the important work with states like California, where CMS made strong forays into how to think about drivers of health and health-related social needs--including around housing supports, nutrition and other pieces--being much more integrated into the fabric of Medicaid. We're looking at this from a care delivery expectation standpoint, and how that might fit into various Medicaid vehicles and frameworks. We expect much more on that including guidance to come in the coming months.

And finally, I would like to note the incredible amount of work that is ongoing with states, advocates, providers and others on both the ongoing, and continued response to COVID, in every respect; as well as how we prepare with states for unwinding from the pandemic. That is one of the top priorities with unprecedented levels of state engagement and thinking about all the levers available to CMS--to make sure we're supporting states, thinking about the operational pieces, and doing everything possible to preserve and protect coverage for folks, whether that be through Medicaid, the Marketplace, or other

coverage vehicles. I echo my colleagues thanks to folks for a very busy year that's just happened and a very busy year ahead. It's an exciting time for Medicaid and CHIP and we have a great desire to work together.

With that, I'm going to turn it over to Dara Corrigan, Deputy Administrator and Director for the Center of Program Integrity for an update on CPI.

DARA CORRIGAN: Thanks so much, Dan. It is a privilege to be with everyone today. And, I thank my colleagues who've spoken already, and the Administrator for setting the ground for what I will be saying. It's not surprising that program integrity runs through every one of our programs. I want to talk a little bit about what we've accomplished last year, and how we are going to be thinking about things in the upcoming year. But I wanted to start by saying that we do work with the other centers, and have the same goal of making sure that our beneficiaries receive the care and benefits that they need.

Our particular perspective is that we want to make sure that we're only paying for care that is medically reasonable and necessary. And, we want to make sure that our beneficiaries are protected against unscrupulous providers and suppliers. These are challenging times with COVID-19, and with program integrity and oversight we have to move to where the risk is. And, with waivers and new medical needs, and programs, and science, we need to put that all together in a way where we can ensure oversight. But it's just as important to us in Program Integrity that we ensure that beneficiaries have access to care.

And while it isn't in the title of our center, we are actually the center that enrolls providers and suppliers. So we're the gateway into the program. And what that means for us in our obligation, and our real commitment to people, is that we will enroll providers and suppliers in the most expeditious and streamlined way possible. We are really trying this year to get off the ground a new way of enrolling providers and suppliers that will rely less on paper, and will hopefully expedite the process even more than it already is.

To give you a sense of the scope of what we do, in fiscal year 2021, we enrolled over 239,000 new providers and suppliers. That gives access to care to approximately 65 million new Medicare beneficiaries. On top of that, of that 239,000 that we enrolled, about 120,000 of those providers enrolled were in the ten states most impacted by COVID-19.

We've also focused this past year on making sure that we are watching out for beneficiaries. For a long time, we've relied on our beneficiaries to let us know when things are happening that shouldn't be happening. They're wonderful sources of information for us in the Center for Program Integrity. It's important to note here that we have an ongoing promotional effort called Guard Your Card that reminds beneficiaries to be very, very vigilant about who is asking you for your information. And I know everyone knows this, but people can be very convincing. They can call, they can send you a message, they can text you, and they will say we can help you if you give us your Medicare card number or Social Security Number. And it's a very sophisticated scam. So we would just urge people, and I urge those on the phone to urge people, to warn people not to give out that information unless they know it is a trusted person.

The other thing I've already said is report suspicious activity to us, and always call 1-800-Medicare with those concerns. For 2022, we will continue to be vigilant about new fraud schemes that appear related to COVID. We had some areas that were particularly susceptible to fraud, where telemarketers were

providing medical equipment, or trying to provide other services that were medically unnecessary or unreasonable, and billing for it. They were billing for telehealth visits where it was something that couldn't be provided by telehealth. And we will continue to pursue those leads and to ensure that the oversight continues in the very focus, tenacious way that it always has. It just pivots depending on where the money is.

I also wanted to share that in 2022, we will be focused more on Medicaid and Medicare managed care. This shouldn't come as a surprise, the more beneficiaries are moving into managed care, and we want to make sure that our oversight follows where our beneficiaries are--to make sure that we are the most responsible that we can be.

And finally, I wanted to explain that in Program Integrity, we are the ones out there doing oversight. But we are also the people who want to help protect not only vulnerable beneficiaries, but vulnerabilities in the program. And what that means is that we not only look at our data to see where vulnerabilities are, we work with the other Centers to ensure that there is a loop. So that we can close those loopholes and prevent fraud and abuse and waste from continuing into the future.

I'm particularly proud of those efforts, and the importance of relying on data and doing data analytics to help with our oversight.

Now, I have the privilege of turning it over to Dr. Lee Fleisher who is the CMS Chief Medical Officer and Director for the Center for Clinical Standards and Quality. Thank you very much.

LEE FLEISHER: Thank you so much, Dara. And Administrator Brooks-LaSure, good afternoon. As a practicing physician I also want to thank my colleagues throughout the health care ecosystem for the work they have done during the pandemic. Establishing and maintaining health and safety standards are foundational to the work we do within CCSQ. These standards, also called the conditions of participation, ensure protections for all beneficiaries across many care settings.

We use select levers, such as survey and enforcement, quality measurement and improvement, and coverage, to build on those standards and drive high quality patient-centered care. We've begun taking a hard look at our programs and policies as we journey toward an equitable system of health, and we ask ourselves, “what impact will the policy or programs have on the availability or quality of services for underserved populations?”

This is just the beginning of our journey, but we've made some headway--including soliciting public feedback on advancing equity in key areas, such as quality measurement and the organ transplantation system. CMS recognizes the vulnerable nature of the nursing home population. Especially with the inherent risks of congregant living. We've learned that limited visitation can be traumatic for residents and their families. CCSQ's nursing home team has worked tirelessly to monitor and adjust visitation guidance as needed.

CCSQ led the development of historic regulation to require COVID-19 vaccination of eligible staff at health care facilities participating in the Medicare and Medicaid programs to ensure patient safety, and provide stability and uniformity across the nation's health care system. Last week, the Supreme Court allowed this requirement to continue. We are also leveraging our quality improvement organizations to assist with education and technical assistance regarding vaccines and boosters, especially in the nursing home community.

CCSQ's coverage team opened a national coverage analysis in which the agency carefully reviewed available evidence to establish a proposed national coverage determination for monoclonal antibodies targeting amyloid for the treatment of Alzheimer's disease. Last week, CMS proposed an evidence-based coverage policy and is now soliciting further feedback from the public.

In December 2021, CMS announced intentions to propose a birthing-friendly designation to drive improvements in perinatal health outcomes and maternal health equity, beginning with whether they have implemented the recommended patient safety practices, or bundles, to improve maternal health and outcomes.

This year, we'll continue building on our 2021 efforts with a few additions. The pandemic, and the breakdown it has caused, presents an opportunity and an obligation to re-evaluate health care safety with an eye towards building a more resilient health care system. We are committed to developing a comprehensive quality strategy, using a person-centric approach to highlight the journey across the continuum of care--including in the area of behavioral health.

CCSQ remains committed to developing a coverage pathway that balances timely, predictable access to high-value emerging therapies with evidence development and beneficiary protections.

In closing, CCSQ is the national voice that leads the development and adherence to health and safety standards, drives care delivery and quality improvement, addresses disparities and injustices and promotes equity and value using evidence and continuous learning to inform our approach.

Thank you for the opportunity to speak with you all today. I would now like to turn it back to Jonathan Blanar who will moderate the question and answer session. Jonathan?

JONATHAN BLANAR: Thank you, Dr. Fleisher. Thank you to all of our speakers for a look back on 2021 and what's on the horizon for 2022. As I mentioned earlier, we solicited questions prior to the call and we will walk through those now. We will not be able to answer the questions in the Q&A chat but we will take those questions back and consider them for future calls and/or for future policy.

I'm going to ask the CMS leaders to please turn on their cameras for the Q&A session. Our first question is to Dan Tsai and Dr. Meena Seshamani. What does CMS plan regarding telehealth coverage and reimbursement? The pandemic has made telehealth much more valuable to both patients and providers. It saves on travel time, and inconvenience for patients, and allows providers to encounter patients in their home environment. Certainly there are times when in-person services are necessary, but telehealth has proven its value and needs to be continued and covered. Dan, I'll start with you.

DANIEL TSAI: Thanks, Jonathan. One of the silver linings of the pandemic is having ushered us all into much more of routine adoption and use of telehealth services, including for critical pieces like behavioral health and other areas where from an equity standpoint and others including use of telephonic telehealth, that we've seen great strides. From a Medicaid standpoint, we support that. We want to see that maintained. We emphasize for all of our colleagues the flexibilities that we've seen states pick up during the public health emergency around telehealth, including the use of telephonic telehealth, exist without the public health emergency, as well. States certainly have the ability to make some decisions about that. We are strongly encouraging states to continue to take advantage of those flexibilities and to continue to seek out as much adoption, with the right constraints around telehealth as possible. That's very much on the Medicaid CHIP side. Meena, would you like to speak on Medicare?

MEENA SESHAMANI: Thanks Dan. And thank you Jonathan for the question. Certainly, through the pandemic, there has been an explosion in innovation and change in how we deliver care. That really does have lessons learned for all of us moving forward. And telehealth is one such area. And I think as we're thinking about innovations, it really does come back to those strategic pillars and the vision of what we want to do to best serve the people who use our programs. So, how can we advance equity? How can we drive that high-quality person-centric care? And how can we be good stewards of our program and promote affordability and sustainability of the program?

And telehealth will be looked at through that same lens. There are opportunities for us, where telehealth can enable improved access and bring care to where people are. We also need to consider the sustainability aspect and how it can support equity--again, both by being able to enable someone who previously had to take two buses to get to a clinic can now see a provider in their home.

But where there are issues of broadband access, for example, and where we find through analyses that perhaps certain communities are not using telehealth as much as others. And what does that mean? I will say in the Medicare program, we did expand and make permanent payments for behavioral health with telehealth, including audio-only for after the pandemic, with the statutory authorities that we were given. And we will continue to work with stakeholders, and with others to really evaluate where there are opportunities to further our mission.

JONATHAN BLANAR: Thank you, Dan and Meena. Our next question is directed to Administrator Brooks-LaSure. Administrator, is CMS including territories, for example Puerto Rico and the Virgin Islands, when designing strategies to reduce disparities in access to care and specialists?

CHIQUITA BROOKS-LASURE: Thanks so much, Jonathan, for raising this important point. We absolutely include when we say “we want to partner with the states,” the District of Columbia and territories. This is such a critical part of ensuring equity, and we as an Administration support parity in terms of payment to territories for the Medicaid program, and really are looking to partner with the territories on Medicare. So it's one that, as we really talk about equity, want to make sure that everyone is included in that work.

JONATHAN BLANAR: Excellent, thank you. Our next question is directed to Dara Corrigan. Dara, has the Center for Program Integrity worked differently with law enforcement during this pandemic?

DARA CORRIGAN: People have asked that question in different ways and I'm happy to address it here, as well which is “have things been really different?” and the answer is, not really. We have long-standing partnerships with the Justice Department, private insurers, states, and the Office of the Inspector General at the Department and what we do is we really, no matter what is happening, we're looking at changes in data to make sure that we are looking in the right places and staying ahead of the fraud, waste and abuse.

But it's clear that in September of last year, there was a nationwide--various nationwide COVID-related scams--and we really do find some bad actors. But there were 138 defendants across 31 districts where the alleged amount of fraud was $1.1 billion. It is clear that oversight is needed. But, the partnership remains the same, and with the commitment of everyone on this call, we're able to work together to ensure that the program integrity concerns are addressed and watched. Thank you for the question.

JONATHAN BLANAR: Thanks, Dara. The next question is for Dr. Ellen Montz. Regarding the first interim final rule in the No Surprises Act, the prudent layperson standard is a critical patient protection that ensures that patients who believe they are having a medical emergency have their emergency care covered by their health plan, regardless of their final diagnosis. Unfortunately, even with this language, some private health plans and state Medicaid agencies are still implementing policies that could potentially be a violation to the prudent layperson standard. What is CMS specifically doing to enforce this important patient protection?

ELLEN MONTZ: Thanks Jonathan. Just quickly, let me scope back out a little bit and answer this more broadly. Which is as I mentioned during my intro--the implementation of the No Surprises Act is active and ongoing. These new consumer protections are incredibly important and have implications across the health care delivery system and regulatory system.

We in CCIIO and across the Administration have put in place active processes whereby we will intake any feedback, implementation experiences, as they arise. I mentioned the website earlier linked to the help desk and complaints line. We also have continued plans to further educate consumers on their rights. So, I just want to broaden and restate my call for your partnership here in helping us implement the law in a way that is most impactful for consumers. With specific respect to your question, we absolutely agree that the prudent layperson's standard is a key component of the protections of the Act. And we did include in the first interim final rule something that was informed by our experiences in enforcing the standard of the ACA.

So with respect to the commercial market, I will say CMS is responsible for enforcing the No Surprises Act in certain states and some components. And in others we work in partnership with the states to enforce the protections of the No Surprises Act and that information, state by state, can also be found on the website, as I mentioned cms.gov/nosurprises. And I will finally say if anyone does believe that rules are not being followed, please contact that help desk to submit it. Thank you.

JONATHAN BLANAR: Thank you, Dr. Montz. That wraps up our question and answer session for today. I do want to thank all of our speakers today, and thank everyone that joined today's national stakeholder call. We do plan to conduct these calls quarterly. So please keep an eye out for the invitation to our next quarter's call. And with that, I would like to turn it back over to the CMS Administrator, Chiquita Brooks-LaSure, for her closing comments.

CHIQUITA BROOKS-LASURE: Oh, thank you, Jonathan. And thank you all for joining us today. I know it feels like a short period of time to go through so much that's going on at CMS. But we absolutely welcome your comments, your perspectives through things like the request for information that we've put out when we're putting out proposed rules and determinations. We encourage those, as well as the variety of ways that we try to make sure that you can get in touch with us through meetings and the like.

So I can't miss an opportunity to encourage everyone to get--if you're a provider, to get your staff and everyone vaccinated and boosted, and we just encourage and thank all of you for all of your hard work with the pandemic. And we'll just close the celebration of Dr. King's life with reminding ourselves that he said “the ark of the moral universe is long but it bends towards justice,” and to know that's what the CMS team, working with all of you, is trying to do. Have a good rest of your day.