CMS Leadership National Call Update
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**Eden Tesfaye:** Hi, everybody, we'll get started soon here as folks hop onto the call. Hello and welcome to the thousands of folks on the call right now. My name is Eden Tesfaye, and I have the pleasure of serving as Senior Advisor here at CMS in the Office of the Administrator. Thanks again for taking time out of your day to join us for our third Centers for Medicare and Medicaid Services (CMS) Leadership National Call Update of 2024. I'm going to walk through a couple of housekeeping items and the agenda and then turn it over to our speakers. As for those housekeeping items, this call is being recorded. For those who want to view American Sign Language, select the interpretation icon on your Zoom task bar, then select American Sign Language to view interpreters in a separate window. Also, while members of the press are always welcome to attend the call, please note that all press and media questions should be submitted using our Media Inquiries Form, which may be found at cms.gov/newsroom/media-inquiries.

We will not be accepting live questions during the call. However, 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 that includes the CMS Administrator, Chiquita Brooks-LaSure, and her leadership team, who will highlight CMS' recent accomplishments, including a more in-depth look at our recent policy announcements and how our cross-cutting initiatives are advancing CMS' strategic plan. These presentations will be followed by a question and answer session. And with that, it is my honor to turn it over to our leader, Administrator Chiquita Brooks-LaSure.

**Chiquita Brooks-LaSure:** Thank you so much, Eden, and just a good afternoon to everyone. As always, it's really a pleasure to be with you and to—just to say thank you for all the work that you do across this country to make sure that we are able to deliver care for the over 160 million Americans who are covered by, as you've heard me say hopefully, the three MPs: Medicare, Medicaid and CHIP (Children's Health Insurance Program), and Marketplace coverage, as well as, of course, all the work that we try to do to ensure the health and safety of facilities across this country. Again, let me start by saying thank you for your partnership and also for the feedback that you give us constantly. And I've appreciated hearing from so many of you about how useful you find this call and appreciate just everything that you do to help us to do the work that we need to do for this agency together.

In just a few minutes, you'll hear from our leadership team to highlight a couple of the tremendous gains that we have made over the last quarter to advance health equity. Things like what we're putting in our Medicare payment rules, our continued efforts to strengthen conditions of participating in our programs and our Innovation Center, just to name a few. As I imagine you

know, this week is the anniversary of Medicare and Medicaid, the round number of 59 years. Happy 59th birthday to our two pillar programs that really ushered in a new age of making sure that Americans in this country are covered, Medicare and Medicaid. So with that, I really will turn it over to our team. You'll hear from Meena Seshamani, Liz Fowler, Dan Tsai, and Dr. Dora Hughes. And I just want to say just a huge thank you to them as well as all the staff at CMS for the hard work. And with that, I'll turn it over to Dr. Meena Seshamani.

**Dr. Meena Seshamani:** Thank you, Administrator, and it's great to be here with all of you today. As the Administrator mentioned, I'm Dr. Meena Seshamani, the Director of the Center for Medicare. And as you all know, our team in the Center for Medicare continues to be busy delivering on our historic work as we are driving towards a future where people with Medicare have access to and receive equitable, high-quality, and person-centered care that is affordable and sustainable across all Medicare programs. Today, I'll cover some recent announcements for traditional Medicare, the Inflation Reduction Act, and Medicare Part D.

Starting with traditional Medicare, CMS released the 2025 proposed rules for the Physician Fee Schedule, Outpatient Prospective Payment System, ESRD (End-Stage Renal Disease) Payment System, Home Health Prospective Payment System, and a standalone proposed rule to address suspect and highly anomalous billing in ACOs (Accountable Care Organizations). So a few highlights from these rules: In the Physician Fee Schedule, proposals are intended to support whole-person care, to enhance primary care, to expand access to behavioral health, oral health, and caregiver training services, and to maintain telehealth services, all of which advance health equity. As one example, CMS is building on lessons learned from over a decade of primary care model tests in the CMS Innovation Center with the proposal in the Physician Fee Schedule to establish an advanced primary care management bundle. This is an important first step as part of a multi-year effort towards a hybrid payment and accountable care in the chassis of the Medicare program, the Physician Fee Schedule. And this proposed payment uses coding describing certain primary care services that would be provided by advanced primary care teams, with adjustments for patient medical and social complexity to promote health equity. These services would be tied to primary care quality measures to improve health outcomes for people with Medicare.

We are also continuing to strengthen the Medicare Shared Savings Program, our permanent ACO program. For the first time, CMS is proposing to allow eligible ACOs with a history of success in the program to have access to an advance on their earned shared savings to encourage further investments. We're also proposing an adjustment to financial benchmarks to further incentivize participation by ACOs that serve people living in rural and underserved communities. And we're continuing to move the Shared Savings Program towards that Universal Foundation of core quality measures to drive further alignment and transformation of care.

Finally, we have provisions across both this Physician Fee Schedule as well as the standalone rule to account for the impact of improper payments or anomalous billing that can collectively improve the accuracy, fairness, and integrity of Shared Savings Program financial calculations. We know that telehealth, behavioral health, and supporting caregivers continues to be important. And that's why for telehealth, we made proposals that would allow CMS to maintain some important and limited flexibilities and reflect CMS' goal to maintain and expand the scope of and access to telehealth services. We also proposed new payments and coding for practitioners

who are assisting people at high risk of suicide or overdose, and for the use of digital tools that further support the delivery of specific behavioral health treatments as well as payments for caregiver training for direct care services and supports.

On the Outpatient Prospective Payment System, notable proposed policies include changes to improve Medicare access for formerly incarcerated individuals and those not in physical custody of penal authorities, separate payments to address pain relief treatments, and a new payment to improve access to cancer services and high-cost drugs for patients served by the Indian Health Service and Tribal hospitals. Just this week, we have also finalized the Inpatient Psychiatric Hospitals, the Skilled Nursing Facilities, Inpatient Rehab Hospitals, and Hospice regulations paid under traditional Medicare, and all of these final rules also advance our priorities for health equity and care delivery transformation, which is so important to the long-term stewardship of the Medicare program. In particular, I want to call attention to the Inpatient Psychiatric Facilities final rule. Among other policies, we finalized revisions to the methodology for determining payment rates as required by the Consolidated Appropriations Act of 2023. These policies support the provision of high-quality behavioral health treatment in inpatient psychiatric facilities consistent with the Biden-Harris Administration's Unity Agenda and focus on addressing the mental health crisis.

So moving from traditional Medicare to the Inflation Reduction Act, we are continuing to make progress on our implementation of the Inflation Reduction Act that lowers drug costs for people with Medicare and the Medicare program. We have engaged in good faith negotiations with manufacturers and will soon announce maximum fair prices. Building on this first year of negotiation, we also released draft guidance for public comment for 2027, the second year of the program. We will issue final guidance this fall. Staying with prescription drugs, starting in 2025, people with Medicare prescription drug coverage, or Part D, will have the most comprehensive benefits since the program was launched in 2006. Yearly out-of-pocket costs for all people with Medicare prescription drug coverage will be capped at $2,000.

We also recently finalized the guidance for the Medicare Prescription Payment Plan that will help seniors to spread out the cost of their prescription drugs across the year if they choose, and this will start next year. People who are enrolled in Medicare Part D who face high cost sharing early in the plan year are more likely to benefit from the program. Prior to the start of the plan year, so before 2025, plans are required to reach out to their enrollees who incurred $2,000 in out-of-pocket costs between January 1 and September 30. Plans are also required to reach out to any enrollee throughout the year who is identified as likely to benefit. We will also release resources explaining the Medicare Prescription Payment Plan ahead of Open Enrollment and Part D plans must also include information in their communications materials. And this is where our partnership with you is so essential, so we can make sure that everybody understands these changes that are coming to help them.

The IRA also redesigns how Medicare pays Part D prescription drug plans. The new program design gives plans more responsibility to manage the drug costs of their enrollees. To help with this transition of the redesigned Part D benefit, CMS just announced the Part D Premium Stabilization Demonstration. This demonstration creates an opportunity for standalone prescription drug plans to promote affordable plan choices and maintain stability for people with

Part D coverage. The demo will enable people with Medicare prescription drug coverage to make enrollment decisions best suited to their prescription drug needs. Plans do not need to rebid to take part in the demo, but they do need to tell us they are participating by August 5. And again, this demonstration is about people, because people with Medicare will continue to save money on their drug costs while having stable, affordable choices of prescription drug plans.

We continue to encourage people with Medicare to consider all their prescription drug coverage options, especially since the improvements under the prescription drug law could mean that there are plans that better meet their needs than their current plan. So as always, people with Medicare should review their health care needs for the upcoming year during the Open Enrollment period and determine if they would benefit from changing plans. They may find a Medicare drug plan with better coverage or a lower premium in 2025 by shopping available plans and comparing costs. And it's important to remember that low monthly premiums may not always be the best overall value for someone's specific needs. We recommend looking at a plan's estimated total costs for the year, including premiums, deductible, and other out-of-pocket costs, especially since now there will be first of its kind, a $2,000 out-of-pocket cap for anybody with Medicare prescription drug coverage in Part D. Medicare Open Enrollment will run from October 15 to December 7, 2024, and additional resources will be available for people with Medicare during that time on medicare.gov and through 1-800-MEDICARE.

And again, I cannot emphasize enough how all of this work is only possible through partnership with you. We appreciate all of the input that we have gotten from you as we have made these policy changes as well as your partnership in making sure that these policy changes and standing up these programs really make a difference to the lives of people who rely on our program. We appreciate the work that you all do in getting the word out about the new benefits available for people with Medicare, and we encourage you to submit your comments to all of our proposed payment rules. Deadlines for submission for each rule can be found on CMS.gov. So again, thank you for joining us today, and I will turn things over to Dr. Liz Fowler. Liz?

**Dr. Elizabeth Fowler:** Thank you, Dr. Seshamani and Administrator Brooks-LaSure. And thanks to all of you for taking time to be with us today. Summer went fast. It's hard to believe it's August 1 already. And a lot has happened since the Innovation Center gave a report on the last quarterly call, so I'm pleased to have the opportunity to provide a few updates on recent models and announcements. I'll start with new model launches. We've had two models start since our last call. The Guiding an Improved Dementia Experience, or GUIDE, model launched on July 1, 2024. GUIDE aims to improve quality of life for people living with dementia, reduce strain on their unpaid caregivers, and enable people living with dementia to remain in their homes and communities longer. CMS is proudly working with over 390 participating organizations building Dementia Care Programs that will serve Medicare beneficiaries in all 50 states and the District of Columbia. Nearly one quarter of participants are in rural areas, and one third of participants operate in areas representing communities with low socioeconomic status.

The Making Care Primary model also launched on July 1 with 133 participants representing 772 practices across eight states. Making Care Primary is one of our newest primary care models that invests and supports primary care practices and notably acts as an on-ramp to value-based care through its intentional approach to reach small, independent, safety net providers, bringing

advanced primary care to beneficiaries in underserved areas. And speaking of Making Care Primary, we continue to make progress on our accountable care goal, that is, having all people with traditional Medicare in a relationship with a provider who's helping them navigate their care and who is responsible and accountable for cost and quality. Building on Dr. Seshamani's remarks, at the last quarterly call in April, we highlighted the new ACO PC (Primary Care) Flex model that will give primary care providers and ACOs a new pathway to join and succeed in value-based care.

The application deadline was extended to August 23, and successful applicants will be notified of selection decisions in mid-October for a model start date of January 1, 2025. And in the 2026 Physician Fee Schedule proposed rule published in July, we included a Request for Information on a potential new pathway to increased specialist engagement in value-based care. Specifically, the model would leverage the MIPS (Merit-Based Incentive Payment System) Value Pathways, or MVPs, framework. Instead of receiving a MIPS payment adjustment, providers would receive a payment adjustment based on a set of clinically relevant MVP measures, and their performance relative to model participants of the same specialty type and clinical profile. Evaluating clinicians on a set of performance measures that more closely is related to the care that they provide, and among clinicians furnishing similar sets of services, could bring greater transparency and accountability to provider payments. We're seeking public input on these ideas and on certain design elements of the potential model concept. The comment period is open through September 10.

As another critical element to our specialty strategy, we proposed the Transforming Episode Accountability Model, or TEAM, in the IPPS (Inpatient Prospective Payment System) proposed rule. Thank you to everyone who provided input and comments. We'll have updates on that model in the IPPS final rule coming very soon. Rounding out the new developments in our specialty strategy, in May we proposed the Increasing Organ Transplant Access model, or IOTA, to increase access to life-saving kidney transplants for patients living with kidney disease. We've proposed IOTA as a mandatory model through notice and comment rulemaking. The comment period closed July 16, and we're currently reviewing comments with the goal of publishing a final rule coming your way very soon.

I'll round out my update with a status report on several of our state-based models. We issued a Notice of Funding Opportunities for both the maternal health model and the behavioral health model since our last call. These state-based models are designed to reduce persistent health disparities in maternal and behavioral health by delivering team-based, person-centered care to improve patients' health outcomes and experiences and by investing in state infrastructure to support access to care, infrastructure, and workforce capacity. States have until September 9 to apply for their behavioral health model and September 20 to apply for what we're calling TMaH, the Transforming Maternal Health model.

Another condition-specific model focusing on longstanding health disparity is our Cell and Gene Therapy Access model, which aims to transform the lives of people with Medicaid living with sickle cell disease by increasing their access to potentially life-changing cell and gene therapies. The model's manufacturer negotiation process is ongoing, and we'll be releasing key terms hopefully to states in late fall. States interested in participating can apply between December and

February. And finally, we announced four state participants in Cohorts 1 and 2 of the States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD model, which is a multi-state model that aims to curb rising health care cost growth, improve population health and health outcomes, and address health disparities. Maryland and Vermont were accepted into Cohort 1. Connecticut and Hawaii were accepted into Cohort 2. These states can receive up to $12 million in funding through cooperative agreements during the first five and a half years of the model to support implementation. Applications for Cohort 3 of the model are open until August 12. CMS will select up to four additional states to participate. As you can tell, there's a lot happening at the CMS Innovation Center, but I'll stop there and turn it over to Dr. Dora Hughes.

**Dr. Dora Hughes:** Thank you, Liz, and good afternoon. Again, I'm Dr. Dora Hughes, Acting CMS Chief Medical Officer and Acting Director of the Center for Clinical Standards and Quality, or CCSQ. CCSQ, along with CMS, is committed to improving safety, quality, equity, and coverage across the care continuum, utilizing all the levers available to CCSQ to promote optimal health for all. Today, I'll be sharing some key proposed rules and activities that help to advance these goals. First, I'd like to talk about our maternal health proposals. As part of the calendar year 2025 Medicare Hospital Outpatient Prospective Payment System—I know, a bit of a mouthful—and the Ambulatory Surgical Center Payment System proposed rule, CMS issued proposed provisions for Maternal Health Conditions of Participation, or CoPs. Given the ongoing maternal health crisis in the United States, which disproportionately impacts racial and ethnic populations, for the first time, CMS is proposing baseline health and safety requirements for hospitals and critical access hospitals, for obstetrical services to advance the health and safety of pregnant, birthing, and postpartum individuals.

Informed by stakeholder input and Requests for Information in the fiscal year 2023 and fiscal year 2025 Inpatient Prospective Payment System proposed rules, this new proposal introduces new requirements for maternal quality improvement efforts. These requirements include baseline standards for the organization, staffing, and delivery of care within obstetrical units, emergency services readiness, transfer protocols for obstetrical patients, and annual staff training on evidence-based maternal health practices and cultural competencies, among other topics. We encourage your feedback. Comments on these rules are due September 9.

Next, I'd like to talk about HIV PrEp (Pre-Exposure Prophylaxis). HIV/AIDS has become much like many other chronic conditions which can be managed with medication and an expectation for a normal or near normal life expectancy. Fortunately, this means we are seeing more people with HIV/AIDS reach age 65, making them eligible for Medicare coverage. The number of traditional Medicare beneficiaries with HIV has more than doubled since the mid-1990s, rising from 42,500 in 1997 to over 100,000 in 2020, a 143% increase. While this is a true success story, new challenges have been raised by patient advocates related to coverage for long-term care and medications as well as the need for continuity in one's providers.

CCSQ is addressing one of these challenges by expanding access to medications used to prevent HIV and individuals at high risk of HIV infection as determined by a physician or other health care practitioner who has assessed the individual's history. For these individuals, CMS has proposed to cover HIV Pre-Exposure Prophylaxis, or PrEP, for HIV under Medicare Part B, as in

boy, as part of a national coverage determination, or NCD. This means that qualifying people with Medicare would not pay anything out of pocket for this medication, no deductibles or copays. Currently, HIV PrEP drugs may be covered under Medicare Part D and are typically subject to a deductible and insurance or copay. In addition to the PrEP drugs, the proposal included coverage of up to seven counseling visits per year, additional HIV screenings, and a screening for hepatitis B, also at no cost to people with Medicare who need these services. Once finalized, this expanded coverage of HIV PrEP, counseling, and screenings will help to reduce rates of HIV and hepatitis B. A fact sheet and FAQs are available on our website.

Moving on to the next topic I'd like to talk about, respiratory season is coming and as we continue to prepare for the fall, we are working to prevent and manage the spread of respiratory illnesses. CMS recently proposed as a part of the calendar year 2025 Home Health Prospective Payment System proposed rule to replace the current COVID-19 reporting standards for long-term care facilities that sunset in December with a new set of requirements that will address a broader range of acute respiratory illnesses including COVID-19, influenza, and RSV (respiratory syncytial virus). We proposed a set of elements to help continued monitoring and surveillance, while also balancing reducing reporting burden for these facilities. The proposed reporting elements include the facility census, resident vaccination status for COVID-19, flu, and RSV, confirmed resident cases of COVID-19, flu, and RSV, and the number of hospitalized residents with confirmed cases of COVID-19, flu, and RSV. CMS believes that continued data collection and reporting of respiratory illnesses outside of public health emergencies will help us monitor rates of these illnesses and identify any outbreaks early when they can be more easily contained.

We'll also know if and where additional assistance may be needed. Additionally, we've also proposed that in the event of a declared or significantly likely event of a declared national public health emergency for acute respiratory illness, the Secretary could activate additional reporting requirements. In addition to these requirements for long-term care settings, we are also focused on similar proposals for hospitals and critical access hospitals. In May of 2024, CMS, as part of the Inpatient Prospective Payment System proposed rule and in collaboration with our colleagues in CDC (Centers for Disease Control and Prevention) and in ASPR (Administration for Strategic Preparedness and Response), proposed to revise the hospital and critical access hospital Conditions of Participation to extend a limited subset of the current COVID-19 and influenza reporting requirements which sunset on April 30, 2024. Specifically, we proposed that hospitals and critical access hospitals would continue ongoing weekly reporting with data related to influenza, COVID, and RSV to the CDC's National Healthcare Safety Network. This includes confirmed cases, total bed census and capacity, and certain demographic information.

Again, CMS continues to believe that sustained data collection and reporting of respiratory illnesses outside of public health emergencies will help hospitals and critical access hospitals gain important insights related to their evolving infection control needs. We believe that this approach will balance the need for robust and accurate data for surveillance with the burden that this can place on facilities and staff. We also propose additional data reporting requirements that could be activated in the event of a declared public health emergency for an acute respiratory illness if necessary. These additional data reporting categories include facility structure and infrastructure operational status, hospital/emergency department diversion status, staffing and

staffing shortages, supply inventory shortages, and relevant medical countermeasures and therapeutics. The comment for the proposed rule closed on June 10, and CMS is currently reviewing the comments received.

Finally for today, I would note that CMS proposed in the fiscal year 2025 Hospital Inpatient Prospective Payment System, or PPS, rule, to adopt a Patient Safety Structural Measure for the Hospital Inpatient Quality Reporting Program and the PPS-Exempt Cancer Hospital Quality Reporting Program, beginning with the calendar year 2025 reporting year, which is also the fiscal year 2027 payment determination. The Patient Safety Structural Measure was developed by a Technical Expert Panel, which was comprised of safety experts, hospital leaders, researchers, and patient advocates. It is an attestation-based measure that assesses whether hospitals demonstrate having a structure and culture that prioritizes patient safety across five domains: leadership commitment to eliminating preventable harm, strategic planning and organizational policy, a culture of safety and learning health systems, accountability and transparency, and patient and family engagement. Patient safety is a critical focus and one of the eight goals of the CMS National Quality Strategy to achieve zero preventable harm. And so with that, I'm going to turn this mic over to Dan Tsai, Deputy Administrator and Director of the Center for Medicaid and CHIP Services (CMCS). Thank you.

**Dan Tsai:** Thanks, Dora. Good afternoon, everybody. Time to talk about Medicaid and CHIP. Just to get ahead on a few things. It's been a very exciting, eventful, impactful time for Medicaid and for the Children's Health Insurance Program. Many of you are—we've updated this group—this community—on some of the very significant rulemaking that over the past several years we've both proposed and refined, and over the course of the spring, finalized. And that along with everything else that we are doing as an administration focuses on making sure that people receiving—were eligible to receive health care coverage through Medicaid and the Children's Health Insurance Program really are able to access coverage easily in a way that we would expect for other payer sources across the country. That it does not require rocket science to renew coverage for kids and families and individuals that are eligible. People can find behavioral health, mental health, home and community-based service providers and can access primary care and the like in a timely way. Those underlie the rules that we put out for managed care within Medicaid, for access and strengthening all different parts of the system within Medicaid and CHIP, and also the eligibility rules that we put out earlier this year that really carried forward many of the improvements in the Affordable Care Act to other populations, and also established really substantial protections for kids. We continue to be deeply engaged with stakeholders, with states, with advocates, with the community, on implementing these rules. They have the potential to be absolutely transformative for the Medicaid program. How we implement them from a federal and state and provider and health plan and advocate and stakeholder community really will determine whether or not we can fully achieve that potential. So that we continue to be really excited by working with a whole lot of folks around.

Three things I want to highlight quickly: One, CCBHC, so our Certified Community Behavioral Health Clinic Medicaid Demonstrations. We, together with our colleagues at SAMHSA (Substance Abuse and Mental Health Services Administration) and colleagues across the administration, and with support by members of Congress, we have been able to expand participation and funding for the CCBHC program. And I just want to say one word about that

because mental health and substance use disorder (SUD) treatment, behavioral health treatment, is so critical across all folks in this country and especially including for individuals that we serve in the Medicaid program. We are the largest payer for mental health and substance use disorder treatment for individuals with serious mental illness and more complex behavioral health, mental health conditions. And in many parts of the country and the delivery systems, it's really hard to access behavioral health care, mental health care. And the CCBHC model really is, it's been proven. There's a valuation that demonstrates how it works. It creates much quicker and clearer access with evidence-based standards for our populations. And so we were able, in June, to welcome together with our colleagues at SAMHSA, 10 new states into the CCBHC demo. That's Alabama, Illinois, Indiana, Iowa, Kansas, Maine, New Hampshire, New Mexico, Rhode Island, and Vermont, which joined eight states that are ready in the CCBHC demo. We're really excited about that. And there are a whole lot of avenues in Medicaid for how CCBHC or CCBHC-like models are implemented. That continues to be a major focus for us to really strengthen access to and outcomes for individuals requiring treatment and services for mental health and substance use disorder.

The second thing I want to note is a whole range of Section 1115 demonstrations, waiver approvals for justice-involved incarcerated individuals. As many of you know, we have 1115 demonstrations approved for a range of states to be able to provide what we call pre-release transitional services for those that are incarcerated, say in a jail or prison, about to be released. Statutorily, there's an exclusion around Medicaid coverage for those individuals and that leads to significant challenges with reentry with people successfully being able to be connected into health care services. And you see challenges in outcomes and disparities, recidivism, all of that. And so over the past month and then earlier, we were able to improve a bundle of about seven additional states—Illinois, Kentucky, Oregon, Utah, Vermont, New Hampshire, New Mexico—to provide through Section 1115 demonstration authority, pre-release services, and coverage for justice-involved individuals, in addition to the four states, which are California, Massachusetts, Montana, and Washington, already in those demos. So that is very exciting. We can talk at length about why that is so impactful. And we have, including those states I just mentioned, a total of 23 states, almost half of states in the country, having come forward, raising their hand to be able to provide services and coverage for pre-release individuals in what is really a common sense way of thinking about health care outcomes and equity and how to close some of the gaps we see in care and outcomes.

And finally, I want to note that in June, we announced 18 states as recipients for grants to implement and expand school-based services. So this has been a continued focus for this administration over the past several years, how to make sure we strengthen and increase access to primary care, behavioral health services and the like, for kids in school-based settings. It's a place where most kids in the country are showing up each day, and it's a place to make sure that we are able to ensure access to health care services. And the grants really help states and their local districts, local LEAs—local educational agencies—to be able to expand and further strengthen access to Medicaid services in school-based settings. So we're really excited by that and have had such a groundswell of excitement, support, collaboration in the community along with their colleagues at ED (Department of Education) at the federal level and at the state level as well. So with that, I think I'm going to pause and I'm going to say Medicaid and CHIP, I hope you love it. I'm going to turn it back to Eden.

**Eden Tesfaye:** Thanks, Dan. We do love it. Appreciate your remarks and thank you to all of our speakers. So as I mentioned earlier on our call, we solicited questions from our partners prior to the call, and now we'll go ahead and go through those questions. And so with that, our first question is for Deputy Administrator and Director for the Center for Medicare and Medicaid Innovation (CMMI), Dr. Liz Fowler. Dr. Fowler, how can folks get more information on whether there is a GUIDE model participant in their area?

**Dr. Elizabeth Fowler:** And by the way, I'm also excited by Dan's announcements. Thank you, Dan. Very exciting. GUIDE participants are posted on the GUIDE model webpage. So if you look at the top of the webpage, there's a GUIDE participant list that's hyperlinked to an Excel sheet with all the participating practices' names and addresses. If you or a family member has been diagnosed with dementia or whom you suspect may have dementia, you can contact a GUIDE participant to schedule an initial comprehensive assessment visit. Note that participants in the established track of the model can start providing GUIDE model services, including those comprehensive assessment visits beginning on July 1, as I mentioned. Participants in the new program track can start providing services next year on July 1, 2025. Thanks for the question.

**Eden Tesfaye:** Thank you so much, Dr. Fowler. Our next question is for the Acting Chief Medical Officer and Acting Director of the Center for Clinical Standards and Quality, Dr. Dora Hughes. Dr. Hughes, why did CMS introduce new Conditions of Participation, also known as CoPs, for OB (obstetrics) services?

**Dr. Dora Hughes:** Thank you for that question. Really, the new CoPs are part of CMS' broader initiative to address the maternal health crisis in the United States. The aim is to improve maternal health outcomes, reduce disparities, and ensure that hospitals providing OB services are adhering to high standards of care.

**Eden Tesfaye:** Thank you, Dr. Hughes. And the next question is for Deputy Administrator and Director of the Center for Medicaid and CHIP Services, Dan Tsai. Dan, how will the reentry demonstrations benefit Medicaid eligible individuals?

**Dan Tsai:** Well, as I said in my remarks, we think these are really, really common sense. We have—it's well documented that many of the individuals involved with the carceral system and reentry are Medicaid eligible and they have a suspension of their coverage while being incarcerated. And so many times, you'll have folks leaving a carceral setting with no appointments lined up, no connection to mental health or social work or primary care, without prescriptions in hand, without a care plan. And that leads to what we observe. People come in and out, and also real challenges from a health outcome, health disparity standpoint. So we are excited that the 1115s, outlining minimum set of services that states would provide to individuals, including mental health and substance use disorder treatment and case management and linkages to a range of other social services. And we're really excited to see how that really improves health outcomes for folks in that community.

**Eden Tesfaye:** Thanks, Dan. Dr. Seshamani, our next question is for you. How would people with Medicare know if the Medicare Prescription Payment Plan is right for them?

**Dr. Meena Seshamani:** Thanks for that question. Both plan sponsors and CMS are providing resources to people. And as I mentioned earlier, Part D plans must include information about the Medicare Prescription Payment Plan in their plan communications materials. Additionally, CMS will release resources ahead of Open Enrollment this fall, which again runs from October 15 to December 7. People with Medicare, State Health Insurance Assistance Programs, other partners like you, will be able to access all of these resources and materials on Medicare.gov, including a cost preview feature that will be in the Medicare Plan Finder and a fact sheet. Updates will also be made to the Medicare & You Handbook describing the Medicare Prescription Payment Plan. And as I said, people really should review their health care needs for the upcoming year during Open Enrollment and determine if they would benefit from changing plans. There are a lot of changes happening to the Medicare prescription drug program, and now more than ever, it's going to be very important for people to look at their options because they may find a Medicare drug plan with better coverage and/or a lower premium in 2025 by shopping available plans and comparing costs. And the last thing I would say is that people with Medicare can also take advantage of the free and objective help we offer to compare plans: Medicare.gov, 1-800-MEDICARE, and our State Health Insurance Assistance Programs. People may also qualify for Extra Help in affording their prescription drug coverage. This was also expanded by the prescription drug law. People should contact their local State Health Insurance Assistance Program to get free help to apply for this financial assistance program.

**Eden Tesfaye:** Thank you, Dr. Seshamani. Our next question is for Dr. Fowler. Dr. Fowler, CMS recently announced several state-based Innovation Center models. Can CMMI explain why states would be interested in participating in the Integrating Behavioral Health Model, also referred to by us as IBH, or the Transforming Maternal Health Model, and if they are allowed to participate in both?

**Dr. Elizabeth Fowler:** Both the Transforming Maternal Health, or TMaH, model and the Innovation in Behavioral Health Model, or IBH—both models focus on developing a person-centered, value-based payment approach to addressing whole-person health for priority populations. The maternal health model will provide funding and support to state Medicaid agencies on workforce expansion, data systems, payment analysis, and quality and safety protocols to improve maternal health outcomes. The behavioral health model will provide infrastructure funding for health IT (information technology) investments and technical assistance for community-based behavioral health practices to improve outcomes. We think both are attractive options for states, and states can participate in both of those models. For states participating in both the behavioral health and the maternal health models concurrently, the condition is that providers themselves cannot participate in both models. Participating hospitals and practices, including FQHCs (Federally Qualified Health Centers) may not simultaneously receive maternal health payments and behavioral health payments. In the event of a state participating in both TMaH and IBH, such providers should work with their states and the CMS Innovation Center to understand their participation options for each model. We encourage interested states to reference a fact sheet on model overlaps on each model's webpage, which explains the policies in more detail for these model overlaps, as well as overlap policies for other CMS models.

**Eden Tesfaye:** Thanks, Dr. Fowler. Our next question is for Dr. Hughes. Dr. Hughes, what is the benefit of the proposed national coverage determination that would cover HIV PrEP for HIV under Medicare Part B?

**Dr. Dora Hughes:** Thank you for that question. As I mentioned in my remarks a bit earlier, we think that the national Medicare coverage of HIV PrEP will increase access to this medication, both the oral and the injectables, which we believe in the long term will result in significant public health, economic, and social benefits by preventing new HIV infections, reducing health costs, and promoting equity and access to essential preventative care. This proposed change reflects an important step towards enhancing preventive health measures for our Medicare beneficiaries at risk of HIV.

**Eden Tesfaye:** Thank you so much for that answer. Our next question is for Dan. Dan, how is CMCS working to ensure the unique needs of children are met by CCBHCs participating in the Medicaid Demonstration Program? And what is CMCS doing to ensure appropriate children-specific CCBHC data is collected and made public?

**Dan Tsai:** By the way, Eden, I just realized you and I are with three other doctors on the screen. So Dr. Hughes, Dr. Seshamani, Dr. Fowler.

**Eden Tesfaye:** And they're all awesome women too, right? At that.

**Dan Tsai:** There you go. So OK, on your actual question on CCBHCs and kids, I think a few things. One, the—in collaboration with SAMHSA and the criteria that have been outlined for CCBHCs, we're collectively very clear that the evidence-based practices and the delivery model really needs to also work for adolescents and youth as well. I think one of the things that has come up in stakeholder discussions is the awesomeness of CCBHCs, and there are opportunities to make sure that all the benefits of the model really are more accessible for children and youth. And so that remains a really important area of focus. And I would say more broadly at CMS, we are writing really important guidance on EPSDT (Early and Periodic Screening, Diagnostic, and Treatment), which if you don't know those acronyms you'll see—you'll hear—more about it shortly from us, that really talks about what kids are entitled to for access to a whole range of services, including around the mental health, SUD side, which will be very relevant to this. And on data, that's really important. I would note there are some evaluations that have found that states where they've had successful CCBHCs, those providers have worked really hand in hand with their child welfare agencies and a range of other agencies to think about all the set of supports, medical and a range of others, required to really improve care supports for kids.

**Eden Tesfaye:** Thanks so much for that, Dan. Dr. Seshamani, my next question is for you. So I know that CMS recently published new rules for prior authorization in Medicare Advantage, also known as MA. If I think a plan might not be following those rules, how can I let folks at CMS know?

**Dr. Meena Seshamani:** Yeah, so as the person who asked the question mentioned, we made significant changes to prior authorization to really make sure that people are able to access the care they need. So if you think that a plan might not be following those new rules, the first place

to start is by contacting the plan. If you are unable to resolve your concern with the plan, then contact us at 1-800-MEDICARE. And when you contact us at 1-800-MEDICARE, you can submit a complaint, or you can also send an inquiry to the Medicare ombudsman.

**Eden Tesfaye:** Thank you for that, Meena or Dr. Seshamani, excuse me. Dr. Fowler, the next question is for you. Will the behavioral health model give states the ability to provide assistance for adoption of electronic health records prior to the implementation of the payment model?

**Dr. Elizabeth Fowler:** Thanks for the question, Eden. And Dan, just for the record, my—our other two colleagues are medical doctors and mine is not a medical degree, so I just need to make that clarification.

**Dan Tsai:** Doctors of Philosophy, Doctors of Medicine.

**Dr. Elizabeth Fowler:** Eden, the short answer is yes. States can support behavioral health practice participants in the pre-implementation phase of the model to develop the necessary infrastructure and capacity to carry out behavioral health model activities. States and practice participants will receive infrastructure funding, which can be used for building IT capacity, establishing and using registries, interoperability solutions, for example. And then states and practices can also apply infrastructure funding towards practice transformation activities like developing new IT and staffing workflows, quality improvement activities, and strategies for outreach to beneficiaries and caregivers. There are two funding vehicles to support these activities: cooperative agreement funding, which is issued to states, and then CMS funding for practices who participate in the Medicare portion of the model.

**Eden Tesfaye:** Thank you, Dr. Fowler. Dr. Hughes, our second to last question of this series is for you. Can you summarize what changes are being proposed in the recent CMS proposed rules regarding respiratory illness reporting?

**Dr. Dora Hughes:** Sure. Thank you for that question. Again, CMS has proposed new rules focused on enhancing the reporting and the tracking of respiratory illnesses, including influenza COVID-19, and the respiratory syncytial virus, or RSV. The aim is to improve public health response, patient outcomes, and resource allocation by ensuring timely and accurate data collection from health care providers as well as long-term care providers.

**Eden Tesfaye:** Thank you, Dr. Hughes. And Dan, our last question of the series is over to you. What other states have submitted Section 1115 demonstrations requests to authorize federal financial participation for services provided to individuals who are inmates of public institutions?

**Dan Tsai:** OK, so we have 23 total states so far as of May—end of May—and we know there's a few other states wanting to—expressing interest in submitting demos. And so close to half of states have submitted 1115 requests to expand coverage for inmates of public institutions. We've approved 11. We therefore are still reviewing 12. And if folks have noticed, we have started clustering together to be able to really move through this unprecedented amount. So I think we've got Arkansas, Arizona, Colorado, Connecticut, Hawaii, Maryland, New Jersey, New York,

North Carolina, Pennsylvania, Rhode Island, and West Virginia all on deck. And if I misread any of the list, please don't quote me. I'm cross-walking different lists here, live. There you go.

**Eden Tesfaye:** Thanks, Dan. And we actually have one more question. I promise it'll be worth y'all's time. Dr. Seshamani, when will CMS announce the prices it negotiated for Medicare's prescription drug program? I know that's probably a question a lot of folks on here have in their own heads, so asking that to you.

**Dr. Meena Seshamani:** Oh, thanks Eden. We will announce any agreed-to negotiated prices by September 1, which is the deadline that is in the prescription drug law.

**Eden Tesfaye:** Thank you so much. That wraps up our question and answer session. Thanks to our speakers and to everybody who joined us today. I want to especially thank you, our partners, for your insight and feedback. Your partnership is fundamental to our mission here at CMS. Now, by the time we see y'all again for our next quarterly call, it'll be Open Enrollment season. And so in the meantime, we hope you enjoy the rest of your summer. Thanks again and have a great day.