2021–2024
CMS Accomplishments

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2021-2024
CMS Accomplishments

The Centers for Medicare & Medicaid Services is the federal agency that provides health coverage through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace. CMS works in partnership with the entire health care community to improve quality, equity, and outcomes in the health care system.

Over the last four years, CMS has carried out an ambitious agenda and a bold plan to meet its mission. During this period, we've faced unprecedented challenges and opportunities: recovering from the disruptions of the COVID-19 Public Health Emergency, supporting the first return to regular Medicaid and Children's Health Insurance Program (CHIP) renewals in three years, and carrying out provisions of the historic American Rescue Plan, the Inflation Reduction Act, and other legislation. Throughout it all, the agency's nearly 6,300 employees have driven health coverage rates to historic highs, and ensured that more than 170 million people across Medicaid, Medicare, and the Marketplace have access quality, affordable health care.

Our work is organized around **six strategic pillars** that together advance health equity, expand coverage, and improve health outcomes. In these efforts we are thoroughly committed to improving customer experience, maintaining responsible program stewardship, driving excellence, and promoting continuous innovation across the agency.

We have accomplished a great deal over the last four years, while establishing a strong foundation for the years to come.

By the Numbers

$1.5B
Estimated yearly out-of-pocket savings for people with Medicare prescription drug coverage in 2026 under the historic first Medicare drug price negotiations

21.3M
Number of people who selected coverage in the Affordable Care Act Marketplaces in 2024, the most ever

$35
Maximum amount Medicare enrollees pay for a month's supply of each covered insulin product, under the Inflation Reduction Act

10 years
Additional years of solvency added to the Hospital Insurance Trust Fund between 2021 and 2024

170M
Number of people covered by Medicaid and CHIP, Medicare, and the Marketplace, as of September 2024

10M
Number of people with Medicare who received free recommended vaccinations in 2023, thanks to the Inflation Reduction Act

8.2%
National uninsured rate, down from 10.3 percent in the last quarter of 2020, due to provisions of the American Rescue Plan and the Inflation Reduction Act

700K
Estimated number of Medicaid & CHIP-enrolled people eligible for a full year of comprehensive health coverage after pregnancy, under the American Rescue Plan

Contents

See how we've made progress on each of our strategic pillars over the last four years:

Advance Equity

All CMS teams have been committed to **advancing equity and addressing the disparities** in our health care system from the beginning of this Administration. This goal is embedded in everything we do, including work that supports the other strategic pillars. Accomplishments include:

Improving maternity care

Through the **Maternity Care Action Plan**, which aligns with the **Biden-Harris Administration's White House Blueprint for Addressing the Maternal Health Crisis**, CMS has seized numerous opportunities to improve maternity care access and quality, improve health outcomes, and reduce disparities. Highlights include:

Postpartum coverage expansion

Under provisions of the American Rescue Plan, CMS has worked with states to **extend continuous postpartum Medicaid coverage to 12 months**, compared to the statutory minimum coverage of 60 days. With Medicaid covering over 40% of all U.S. births, this is a historic extension of critical health care services to a population facing inequitable health care outcomes. Nearly 700,000 individuals in 46 states, the District of Columbia, and the U.S. Virgin Islands are estimated to now be eligible for these extended postpartum benefits.

A new model for maternal health

The **Transforming Maternal Health (TMaH) Model,** announced in 2023, represents a groundbreaking investment to improved maternal health. The model will provide funding and technical assistance to help up to 15 state Medicaid agencies develop a whole-person approach to pregnancy, childbirth, and postpartum care, addressing physical, mental health, and social needs.

- The model's goal is to improve access, reduce disparities, and improve outcomes and experiences for mothers and newborns.
- The model will address gaps in maternal health care through activities like supporting access to midwives and doulas, improving prenatal care for chronic conditions like diabetes and hypertension, and reducing complicated procedures like c-sections for low-risk mothers.
- The model will promote a more positive and supportive care experience and help mothers participate in the development of their birth plan.

A commitment to maternal care quality improvement

For the first time, CMS proposed baseline health and safety requirements for obstetrical services in hospitals, including critical access hospitals. The proposal includes **new requirements for maternal quality improvement efforts**, including: baseline standards for 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.

Medicaid Maternal and Infant Health Initiative

CMS' **Maternal and Infant Health Initiative**, which works with state Medicaid and CHIP agencies to improve care access and quality for pregnant and postpartum people and their infants, focused from 2021 to 2023 on infant well-child visits, postpartum care, and low-risk cesarean delivery.

- As part of these efforts CMS published a **Postpartum Care Toolkit** and **checklist** to help partners access resources as states chose to extend Postpartum Medicaid coverage.
- Starting in 2024, reporting on quality measures in the Medicaid and CHIP Child Core Set and the behavioral health measures in the Medicaid Adult Core Set will become mandatory for state Medicaid and CHIP agencies. This requirement includes several measures of maternal and perinatal health and will result in more complete, comprehensive data on the quality of maternity care delivered through Medicaid and CHIP.
- In 2024, CMS released a **web page** to address the recent increase in congenital syphilis among newborns.

Birthing-Friendly designation

In 2023 CMS rolled out the first **Birthing-Friendly designation**, a consumer-facing indicator that a hospital or health system is committed to improving the quality of maternity care they provide. The designation creates incentives for hospitals and systems to improve their maternity care and helps consumers choose facilities with a demonstrated commitment to maternity care quality.

- Health plans and hospitals covering more than 150 million Americans have **committed to using the designation in their provider directories**.
- This designation is displayed on the **Care Compare** section of the CMS website.

Ensuring access to abortion when needed for stabilizing emergency care

Following the *Dobbs v. Jackson Women's Health* Supreme Court decision overturning *Roe v. Wade*, **CMS issued clarifying guidance on the Emergency Medical Treatment and Active Labor Act** (EMTALA). This guidance reaffirmed that patients in any state have the right to stabilizing care if they present with an emergency medical condition at a covered hospital's emergency room. **Where abortion care is the necessary stabilizing treatment in those situations, EMTALA protects that care**. Covered hospitals in all states are required to offer such stabilizing health- and life-saving care.

Taking action on sickle cell disease

In 2023, CMS completed a plan to address barriers and challenges faced by patients with Sickle Cell Disease (SCD). **The Sickle Cell Disease Action Plan** highlights actions in four key areas: expanding coverage and access; improving quality and the continuum of care; advancing equity and engagement; and examining data and analytics. CMS programs are **taking actions outlined in this plan to improve equitable access, outcomes, and quality of care for people living with SCD** and their families.

- Sickle Cell Disease disproportionately impacts people of color, including Black and Hispanic communities. It affects over 100,000 Americans, and 1 out of every 365 Black or African American births. Over half of people with SCD are enrolled in Medicaid or CHIP.
- One element of the plan, the **Cell & Gene Therapy Access Model**, aims to improve the lives of Medicaid enrollees living with SCD by **increasing access to novel and potentially transformative gene therapy treatments**. The model has the potential to reduce health care costs and burdens on state Medicaid programs.

- In 2024, CMS launched a new **web page** that includes a **slide deck** presented to state Medicaid and CHIP officials; reports on demographics, health, and healthcare of individuals with SCD; and quality improvement tools that states can use to improve care for individuals with Sickle Cell Disease.
- As part of National Sickle Cell Awareness Month in September 2024, CMS released a toolkit designed to help front-line clinicians caring for people with SCD. The toolkit includes CMS resources that promote accessible, high-quality care for SCD.

Rewarding excellence in caring for underserved populations

In 2023, CMS introduced **Rewarding Excellent Care for Underserved Populations** (REUP), which rewards providers that deliver high quality care to high percentages of underserved populations. This both incentivizes quality care for these populations and ensures equitable payment for providers disproportionately serving underserved communities.

- New policies in Traditional Medicare and Medicare Advantage, like the Star Ratings Health Equity Index and enhancements to the requirements plans must meet to demonstrate network adequacy, **create incentives for excellent care of underserved populations**.
- As of 2023, **88% of CMS quality programs had an equity component** (including the REUP approach), with a goal of reaching 100% by 2025.

88%

CMS quality programs with an equity component

Addressing social needs of patients

CMS has taken several important actions in the Medicare program and through state Medicaid initiatives to **ensure health care systems can serve patients holistically by accounting for Social Determinants of Health (SDOH)**, which include food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. These factors often affect people in underserved areas disproportionately and can contribute to poor physical and mental health.

Under Medicare:

- CMS expanded coverage in the Medicare Annual Wellness Visit to include an optional **Social Determinants of Health Risk Assessment**. This may help clinicians understand their patients better and provide more holistic care.
- CMS now includes in its quality ratings each hospital's rate of patients screened for the five health-related social needs.
- CMS also finalized coding and payment for services that help patients with health-related social needs access additional care, including with auxiliary personnel like community health workers, care navigators, and peer support specialists.

We have heard from stakeholders that these conversations – and efforts to address these needs – have significantly increased, and from enrollees who appreciate this attention to their social needs. These outcomes are consistent with the Administration's goal of advancing health equity for all, including historically underserved and under-resourced communities.

Under Medicaid:

- CMS created groundbreaking opportunities for states to improve the health of their residents by addressing unmet health-related social needs. This innovation supports the core goal of connecting people with evidence-based interventions that strengthen access to health care and improve health outcomes and health equity.
- Under the Biden-Harris Administration, CMS has approved demonstration projects addressing health-related social needs in 10 states.

- In November 2023, CMS released a **health-related social needs framework** that outlines which services and supports can be covered by Medicaid and CHIP. For example, for people with specific clinical conditions, states can cover housing transition and navigation services, home remediations like air filtration improvements, and medically-tailored meals.

Reaching people in more languages

CMS has **continued to expand its reach into diverse communities with publications in languages** in addition to English and Spanish.

- Between 2021 and 2024 CMS **added six new languages** to its list of those into which it translated one or more publications, bringing the total to 43 languages. For the first time the agency has produced materials in Ukrainian.

43

Languages one or more CMS publications are translated into

- In 2021 the Medicare & You handbook was translated into Chinese, Korean, and Vietnamese for the first time, and for 2025 it has been translated into Arabic, Russian, and Tagalog (online only). It is now available in **28 languages in addition to English**.
- The No Surprises Help Desk, established in 2022, offers consumers help with their medical billing situations in **over 350 languages**.

Advancing equity through research

Under the **Minority Research Grant Program**, CMS from 2022 to 2024 awarded over $3 million to 11 new grantees, all minority-serving organizations seeking to address health disparities, to investigate the root causes of disparities and to disseminate research.

In 2023, CMS awarded $90,000 under the **Health Equity Data Access Program** to three new grantees to gain access to CMS data to conduct health services research on underserved populations.

Bringing together equity stakeholders

In 2023 CMS hosted the **inaugural CMS Health Equity Conference**, where over 5,500 in-person and virtual participants learned about the importance of acknowledging historical and persistent injustices, addressing the social drivers of health, and partnering with diverse communities and organizations to reduce health disparities.

- A second conference was held in 2024 with the same levels of attendance.
- In 2024, CMS Health Equity Awards were given to two organizations demonstrating results in reducing health disparities.

Expand Access

Over the past four years more Americans than ever have gained coverage thanks to an unprecedented effort across CMS to implement the American Rescue Plan, the Inflation Reduction Act, the Affordable Care Act, and other legislation. In addition, our programs have taken historic actions to expand access to necessary care to those with and without coverage and to drive down costs for consumers.

Reaching record Affordable Care Act (ACA) enrollments

A **record 21 million people selected health insurance coverage** through the ACA Marketplaces in 2024, compared to 12 million in 2021. This was supported by provisions of the American Rescue Plan and the Inflation Reduction Act, which increased affordability for consumers, and by an investment of nearly $100 million in grants to 57 Marketplace Navigator organizations.

Record coverage

As of 2024, **45 million Americans have coverage under the Affordable Care Act, including Marketplace plans, Medicaid expansion, and Basic Health plans**, the most on record. This represents 14.1 million more people than in 2021, a **46 percent increase**.

45M

Americans with coverage under the Affordable Care Act, including Marketplace plans, Medicaid Expansion, and Basic Health Plans, 2024

Affordable coverage

Most consumers qualified for $0 premiums or are saving at least $800 per year on their premiums. Four out of five HealthCare.gov customers had health coverage options of $10 per month or less. 44% of consumers selected a plan costing $10 or less.

Improvements to HealthCare.gov

Healthcare.gov made **significant improvements over the past several years**, all designed to make it easier for people to enroll in plans.

- Standardized plan options are now available with simplified plan designs and a set of important services covered with no deductible. New limits on the number of non-standardized plans reduce choice overload.
- Under the 2023 Choice Architecture initiative, gentle "nudges" were added inviting people eligible for high levels of cost-sharing reductions to consider Silver plans, and encouraging all users to consider plans based on overall affordability.
- Since 2021 users of HealthCare.gov have benefitted from other significant improvements, including a redesigned Eligibility Notice and start page, easier navigation through the application, and simplified presentation of plan information.

Protecting and expanding access to contraception

Subsequent to President Biden's Executive Orders in July 2022," **Executive Order on Protecting Access to Reproductive Healthcare Services**," and in June 2023, "**Executive Order on Strengthening Access to Affordable, High-Quality Contraception and Family Planning Services**", CMS took several decisive actions following the Supreme Court's decision to overturn *Roe v. Wade*.

- In June and July 2022, working with the Departments of Labor, Treasury, and Health and Human Services, CMS **issued a letter** and **guidance** reminding private health plans that they are required to provide birth control and family planning counseling at no additional cost under the Affordable Care Act. The action came in response to complaints that the health insurance industry was failing to provide contraceptive coverage consistent with standards set forth by the Departments.
- In January 2023 the Departments **proposed a rule to expand and strengthen access to birth control** so that all women who need or want it can obtain it at no cost, including in some cases where their employer has sought an exemption from the requirement to provide contraceptive coverage.
- In May and June 2024, CMS investigated and required two issuers to correct violations of the Departments' contraceptive rules.
- In August 2024, CMS released a **Center for Medicaid and CHIP Services Informational Bulletin** that reminds states of their obligations under Medicaid to cover family planning services and supplies, and encourages states to implement strategies to reduce barriers and increase access to contraception.

Lowering Medicare drug costs

Under the Inflation Reduction Act (IRA), the agency took **several unprecedented actions to reduce drug costs for people with Medicare**. These actions provide meaningful financial relief for millions of people by improving access to affordable treatments and strengthening the Medicare program both now and in the future.

First-ever drug price negotiations

For the first, time, Medicare **negotiated prices directly with participating drug companies** to improve access to some of the costliest and most dispensed brand-name drugs used by people with Medicare. In August 2024, CMS announced negotiated prices for the first ten drugs selected for negotiation.

- The agency estimates that **people with Medicare prescription drug coverage will save about $1.5 billion in out-of-pocket costs** when the negotiated prices go into effect in 2026, and if the prices had been in effect in 2023, Medicare would have saved $6 billion.
- Drugs selected in the second cycle of negotiation will be announced by March 1, 2025 and will include up to 15 drugs.

$35 insulin

CMS **capped out-of-pocket costs for insulin at $35 per covered insulin product for a month's supply** for people with Medicare, saving more than 1.5 million people nearly $500 per year each. Previously, people with Medicare paid about $63 per insulin fill.

Cap on out-of-pocket drug costs

Total out-of-pocket drug costs are now capped under Medicare Part D plans for certain people with especially high prescription drug costs, providing much-needed financial relief for seniors and people with disabilities who need to take costly medications. In 2025, thanks to the Inflation Reduction Act, **out-of-pocket yearly drug costs for all people with Medicare prescription drug coverage will be capped at $2,000.**

$2K

Maximum Medicare out-of-pocket yearly drug costs in 2025

Rebates on unreasonable prices increases

The Inflation Reduction Act r**equires drug companies that raise their drug prices faster than the rate of inflation to pay Medicare a rebate**. This will discourage unreasonable price increases by drug companies and save money for consumers. The rebates contribute to a stronger Medicare for current and future enrollees.

Free recommended vaccinations

People with Medicare Part D drug coverage now **pay nothing out-of-pocket for vaccines** recommended by the Advisory Committee on Immunization Practices (ACIP).

- Over **10 million people with Medicare Part D received a free vaccination in 2023, up from 3 million in 2021**.
- In addition, **most adults with Medicaid and CHIP are guaranteed ACIP-recommended vaccines at no cost** to them.

Extra Help with drug costs for low-income people

In 2024, **CMS expanded eligibility for full benefits under the Low-Income Subsidy ("Extra Help")** program, which helps people with Medicare Part D afford their prescription drugs.

- As of early 2024, nearly **300,000 low-income people with Medicare enrolled in Extra Help benefited from the additional assistance under the Inflation Reduction Act**, like no deductible, no premium, and fixed or lower copayments for certain medications. They save up to $300 per year on average.
- An **outreach effort continues to focus on the 3 million seniors and disabled people who are likely to be eligible** but are not yet enrolled in Extra Help. As of April 2024, the campaign has produced close to 2 billion views across digital, radio, and outdoor media; a direct mailing was sent to 1.9 million people. CMS has translated some outreach materials into Chinese, Vietnamese, and Korean.

Improving Medicare access

Easier Medicare Savings Program enrollment

In 2023, CMS finalized a rule **making it easier for people to enroll in and keep Medicare Savings Program (MSP) coverage**. Through the MSPs, state Medicaid agencies pay an enrollee's share of Medicare monthly premiums and usually other out-of-pocket costs, freeing up limited income for food, housing, and other essentials. **The rule cuts red tape and reduces costs for millions of seniors and people with disabilities.**

- CMS estimated that 860,000 individuals will newly enroll in MSPs under the rule.
- CMS estimated that **the rule will save individuals nearly 19 million hours of paperwork each year**, as well as $87 million on transportation, copying, postage, and related costs. State government agencies will save 2 million hours each year.

Actions on unethical marketing in Medicare

In April 2023, CMS finalized a rule to crack down on misleading marketing schemes by Medicare Advantage plans, Part D drug plans, and their downstream entities.

- For 2024 Medicare Open Enrollment, CMS prospectively **rejected more than 1,000 of the 3,000 MA marketing TV ads submitted for review**, and 80 percent of ads submitted by third parties.

1K

Medicare Advantage TV ads CMS rejected under new rules cracking down on misleading marketing

Medicare.gov improvements

To help people understand the Medicare program and take the enrollment and coverage action that's right for them, the Medicare.gov team made improvements to the "New to Medicare" pages of the site starting in 2021. **Customer satisfaction for visitors who used those pages increased by almost 40 percent** from 2021 to 2024.

Strengthening and expanding Medicaid and CHIP coverage

Medicaid and CHIP are the largest health coverage programs in the country, together covering over 80 million people as of May 2024. Over the past four years, the programs faced the unprecedented challenge of returning to regular Medicaid and CHIP renewals when COVID-19 pandemic-era continuous enrollment conditions ended in 2023, while also supporting Affordable Care Act Medicaid expansion in four more states, integrating services that support health-related social needs, extending postpartum coverage to 12 months in 46 states, D.C., and the U.S. Virgin Islands, and strengthening the delivery of critical behavioral health and substance use disorder services to adults, youth, and children.

Support and protection for Medicaid and CHIP renewals

Since 2023, when Medicaid and CHIP eligibility renewals restarted, CMS has taken multiple actions to help eligible people renew Medicaid and CHIP coverage and help others transition to different coverage options, like Marketplace plans. This included the following "unwinding" actions:

- Establishing strategies for states to make it easier for people to renew Medicaid or CHIP coverage - and approving over 400 of them
- Working to make transitions between Medicaid and Marketplace coverage easier, by offering a HealthCare.gov Special Enrollment Period, enhancing account transfers, and supporting direct assister outreach to people who may have lost Medicaid coverage
- **Partnering with the U.S. Digital Service** to improve state systems and auto-renewal rates, helping **increase auto-renewal rates nationwide from about 25% in April 2023 to 46% in January 2024**
- Holding states accountable for federal renewal requirements, including by requiring the **reinstatement of more than 400,000 children and families** after identifying a systems issue across 29 states
- Engaging partners across the country to conduct outreach and raise awareness among people with Medicaid and CHIP coverage, and creating a **one-stop hub** of resources for partners
- Raising awareness through a first-of-its-kind national paid advertising campaign through online and offline channels, earned media, engagement with community groups, and outreach materials for different communities. **The digital campaign delivered a total of 6.6 billion views** and 13.8 million clicks in English; in Spanish, 850 million views and over 2.2 million clicks.

As a result of these and other actions, since December 2023, **coverage for over 60% of individuals due for renewal was successfully renewed**. Despite the disruptions in many states, total Medicaid and CHIP enrollment in May 2024 was 14% higher, or 10 million people above , enrollment in February 2020, just before the COVID-19 pandemic.

10M

Increased enrollment in Medicaid and CHIP in May 2024, compared to February 2020

Streamlined Medicaid, CHIP, and Basic Health Program enrollment and renewal

Responding to Executive Orders to strengthen Medicaid and improve access to affordable, quality health coverage, CMS released a **final rule that will make it easier for millions of people to enroll in and retain coverage in Medicaid, CHIP, and the Basic Health Program**. The rule:

- Allows children with CHIP to re-enroll without a lock-out period when a family fails to pay a CHIP premium
- Prohibits waiting periods that delay CHIP enrollment
- Eliminates the requirement to apply for other benefits as a condition of Medicaid eligibility, to ensure applicants and people with coverage are not facing unnecessary administrative hurdles

First-ever appointment wait time standards for Medicaid managed care

CMS for the first time established **maximum appointment wait time standards for people with Medicaid health plans**, so they can count on getting a doctor's appointment without waiting several weeks or months.

- The final rule requires all states to establish **maximum wait times of no more than 15 days for enrollees to see their primary care and maternity care providers**, and no more than 10 days for mental health and substance use disorder appointments. These maximum wait time standards are applied separately to adults and children to ensure timely access to care for both groups.
- The rule also requires states to conduct annual secret shopper surveys to confirm compliance with wait time standards and the accuracy of provider directories.

Medicaid provider rate transparency

In two rules finalized for the Medicaid program – the **Access rule** and **Managed Care** rule – CMS will **require states to compare Medicaid and Medicare payment rates** for primary care, obstetrician/gynecologist, mental health, and substance use disorder providers, for both fee-for-service and managed care. Transparency into Medicaid payment rates across states will provide greater insight into how Medicaid payment levels can affect access to care.

Expanded Medicaid Access for American Indians and Alaska Natives

CMS works in close partnership with the American Indian and Alaska Native communities and leaders to advance access to culturally competent health care to people eligible for Medicaid and CHIP coverage. This Administration has made significant strides to strengthen and expand access for all American Indians and Alaska Natives:

- CMS has proposed to **update the Medicaid clinic services regulation** to enable **reimbursement for services furnished outside the "four walls" of a freestanding clinic by Indian Health Service (IHS)/Tribal clinics**.
- CMS has proposed, starting January 1, 2025, to separately pay IHS and tribal hospitals for high-cost drugs furnished in hospital outpatient departments through an add-on payment.

Investment in Home and Community Based Services

Over the last four years, CMS has taken a series of actions to strengthen and improve access to Home and Community Based Services (HCBS). These actions represent an opportunity for states to address existing HCBS structural issues like supporting the direct care workforce, expanding the capacity of critical services, and meeting the needs of people on HCBS waiting lists and family caregivers.

As a result of the American Rescue Plan, states plan to **invest $37.1 billion in activities to enhance, expand, or strengthen Home and Community Based Services**. States chose to invest the vast majority of dollars in recruiting and retaining direct care workers, including by increasing pay, establishing career paths, and creating registries to help match people receiving HCBS with providers.

$37.1B

Planned state investments in home and community based health care activities, as a result of the American Rescue Plan

Under the **final Access rule** released in 2024, states are required to allocate at least 80% of Medicaid HCBS payments directly to care workers providing these services, as opposed to administrative overhead or profit.

Continued Medicaid expansion

Between 2021 and 2024, CMS supported the ACA coverage expansion of Medicaid to low-income adults under the Affordable Care Act in four more states: Missouri, South Dakota, North Carolina, and Oklahoma.

- In total, **over 23 million people now have health coverage under ACA Medicaid expansions**, up from 18.7 million in 2021.
- Forty states plus D.C. have now expanded their Medicaid programs under the ACA.

Required quality rating systems for Medicaid and CHIP plans

Under the **Medicaid managed care rule** published in 2024, **states will be required to establish a quality rating system for Medicaid and CHIP managed care plans**. This **Medicaid and CHIP Quality Rating System** will provide a "one-stop-shop" where people will be able to access information about Medicaid and CHIP eligibility and managed care; compare managed care plans based on quality and other factors key to decision making, such as the plan's drug formulary and provider network; and ultimately select a plan that meets their needs.

Expanding oral health care access

Oral health affects individuals, families, and communities and is central to overall health and well-being. Access to oral health services is critical to achieve the best, most equitable health outcomes. Accomplishments in **oral health** since 2021 include the following:

Medicare payment for important dental services

In 2022 and subsequent years, CMS took action to ensure that **Medicare will pay for dental services inextricably linked to other covered services.** This will increase success of these treatments, improve access to care, and reduce disparities in oral care and overall health. Covered dental services include those related to the following:

- Chemotherapy and head and neck cancer treatments
- Organ transplants (including stem cell and bone marrow transplants)
- Cardiac valve replacements
- Valvuloplasty procedures

A proposed rule for 2025 includes a proposal to pay for dental services inextricably linked to Medicare-covered dialysis services, and solicits comments on potential connections between dental services and immunosuppressive therapies, sickle cell disease, and hemophilia.

Dental coverage for pregnant or postpartum Medicaid enrollees

As of October 2022, all 50 states and D.C. offer some **dental coverage for Medicaid enrollees who are pregnant or postpartum** through at least 60 days after pregnancy.

Mandatory reporting of oral health quality measures for Medicaid and CHIP

Starting in 2024, states are required to report the **Core Set of Children's Health Care Quality Measures** for Medicaid and CHIP. Measures include those related to **oral exams, fluoride application, and dental sealants**.

Improvements to Marketplace dental plan pricing, selection, and availability

CMS has recently taken action to ensure Marketplace consumers have better access to quality dental coverage options.

- Starting 2024, CMS requires issuers of stand-alone **dental plans in the Marketplaces to submit guaranteed rather than estimated rates**, reducing risk of incorrect premium tax credits and consumer harm for those who select dental plans.
- CMS announced policies that for the first time allow states to **include routine adult dental services as an essential health benefit**, expanding access to this critical health care.
- Healthcare.gov introduced improvements that make it **easier for consumers to select stand-alone dental plans** and determine if their dental providers are in a plan's network.

Protecting nursing home residents

This Administration took several unprecedented actions to allow people to make more informed decisions about where to get nursing home care for their loved ones, and to expand access to high-quality care.

- In 2024 CMS issued the first **national minimum nurse staffing standards** to ensure access to safe, high-quality care for over 1.2 million nursing home residents. For the first time, long-term care facilities certified by Medicare and Medicaid **must have a Registered Nurse on site 24 hours a day, 7 days a week** to provide skilled nursing care.
- CMS also issued a rule that will provide greater transparency into **who owns a nursing home** and whether the ownership includes a private equity firm or real estate investment trust.
- **Ownership information** for all Medicare-Certified **Hospice**, **Home Health Agencies**, **Federally Qualified Health Centers**, and **Rural Health Clinics** was also made publicly available for the first time to help families identify the best care for their loved ones.

24/7

When long-term care facilities must have Registered Nurses on duty under standards issued in 2024

Expanding and improving behavioral health

The **CMS Behavioral Health Strategy** developed under this Administration focuses on three key areas: substance use disorders prevention, treatment, and recovery; ensuring effective pain treatment and management; and improving mental health care and services.

Equitable access to mental health and substance use disorder care

As part of the Administration's effort to ensure that more than 150 million people with private health coverage have **greater access to mental health and substance use disorder care, the departments of Labor, Health and Human Services, and Treasury issued final rules to expand equitable access to these benefits** as compared to medical and surgical benefits and reduce barriers to accessing these services.

- The rules build on the departments' commitment to achieving the full promise of the Mental Health Parity and Addiction Equity Act of 2008.
- The new rules add **protections against more restrictive, nonquantitative treatment limitations for mental health and substance use disorder benefits** as compared to medical or surgical benefits. Nonquantitative treatment limitations are requirements that limit the scope or duration of benefits, such as prior authorization requirements, step therapy, and standards for provider admission to participate in a network.

Support for community-based crisis intervention

By the end of 2024, CMS approved Medicaid plans in 20 states and D.C. to support **24/365 community-based mobile crisis intervention services** for individuals experiencing a behavioral health or substance use crisis, made possible by the American Rescue Plan.

- Community-based mobile crisis intervention services can respond quickly to crisis situations and provide individual assessment and crisis resolution.
- Providing immediate and appropriate care to someone in crisis may reduce the need for costly inpatient services.

School-based behavioral health services

School-based health services play an important role in the health of children and adolescents. While schools are primarily providers of education, the school setting offers a unique opportunity to enroll children in Medicaid, facilitate access to coverage, and provide physical and mental health services directly. Over the last four years, CMS has made significant investments in school-based health services, making it easier for schools to bill Medicaid for physical and mental health services made possible by the Bipartisan Safer Communities Act.

- CMS released an updated **Medicaid school-based services claiming guide** to make it easier for schools to bill Medicaid directly for health services.
- In 2023 CMS launched, in partnership with the U.S. Department of Education, a **Technical Assistance Center** to help both state Medicaid agencies and state and local education agencies expand Medicaid school-based services.
- In 2024, CMS awarded $50 million in grants to 18 state Medicaid agencies in support of expanding school-based services.
- During this Administration, CMS has approved the expansion of school-based services to five additional states. As of June 2024, schools in 18 states can now be reimbursed for Medicaid-covered services for all eligible children.

$50M

Grants to states to support school-based Medicaid services

Improved access to behavioral health care for people experiencing homelessness

- In 2023, CMS issued **a new place of service code for street medicine**, allowing providers to bill Medicare and Medicaid for street medicine services nationwide. Street medicine is defined as health services provided to unsheltered homeless individuals in non-permanent locations, like the street or other found environments. These can include preventive, screening, diagnostic, and treatment services.

CMS also issued an **Informational Bulletin** to advise state Medicaid agencies on opportunities for improving access to mental health and substance use disorder services for Medicaid and CHIP enrollees experiencing homelessness.

Strengthened behavioral health services to children and youth

Medicaid and CHIP provide health coverage to almost half of all children in the country and are together the largest payers of public mental health services. CMS has taken significant actions to strengthen Medicaid and CHIP coverage of behavioral health services for children and youth.

- CMS released new, comprehensive Early Periodic Screening, Diagnostic, and Testing (EPSDT) guidance to support states in providing robust and comprehensive health coverage for children and youth enrolled in Medicaid and CHIP. The requirement entitles Medicaid-enrolled children and youth to the full range of medically necessary health care services, including prevention, screening, and treatment for physical health and behavioral health conditions.
- CMS released **guidance describing how states can leverage Medicaid, CHIP, and other federal programs to deliver behavioral health services for children and youth**.

Broader access to specialist care

In 2023, CMS released guidance on **coverage and payment of interprofessional consultation services**. For the first time ever, state Medicaid and CHIP programs will be able to pay specialists directly when a patient's primary health care provider asks for advice. For example, if a pediatrician consults with a specialty behavioral health provider about a specific patient's needs, both providers can be reimbursed for their care – even if the patient is not present. This move links routine care with specialty care, allowing more people to benefit from practitioners with specialized knowledge.

Improved access to behavioral health providers in Medicare

CMS took important actions to ensure that people with Medicare have improved access to providers of behavioral health care.

- CMS carried out legislative changes that allow Marriage and Family Therapists and Mental Health Counselors to enroll as Medicare providers. As of February 2024, more than 21,000 of these professionals enrolled to provide behavioral health services to patients with Medicare.
- In 2023 CMS **finalized rules that improve access to behavioral health services to people with Medicare Advantage** - strengthening behavioral health network adequacy, establishing wait time standards, and including behavioral health services in care coordination programs.

21K

Mental Health Counselors and Marriage and Family Therapists newly enrolled in Medicare as of February 2024

Improved access to peer support services

CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can play an important role in the delivery of effective treatment. In 2024 CMS released **guidance strongly encouraging states to expand the availability and use of peer support services** to serve adults, youth, and families with mental health conditions and substance use disorders. The agency also clarified how states can cover peer support services under Medicaid and CHIP.

Expanded access to behavioral health in rural areas

CMS has **proposed to allow states to be reimbursed for behavioral health services provided outside the "four walls" of clinics located in rural areas**. This is in addition to a similar proposal for Indian Health Service/Tribal clinics. If finalized, this policy would significantly expand access to essential health care, particularly for people living in rural areas.

Behavioral telehealth services in Medicare

CMS finalized policies that **permanently expand access to telehealth for behavioral health services** for people with Medicare.

Behavioral health innovation

CMS announced the **Innovation in Behavioral Health Model** that aims to improve the overall quality of care and outcomes for adults living with mental health conditions and/or substance use disorders, and support community-based behavioral health practices in delivering whole person care.

Preventing surprise bills, reducing barriers to getting care

Since 2002, CMS has been implementing the No Surprises Act, protecting consumers from unexpected medical bills – including high costs when insured consumers get emergency care, when care is provided by out-of-network providers at an in-network facility, and when air ambulance care is used. The law is **preventing an estimated 1 million surprise bills per month**.

1M

Estimated surprise bills prevented per month by the No Surprises Act

- These protections can r**educe barriers to care** due to fear of high unexpected bills.
- A supporting **website within cms.gov** informing consumers of their rights and helping them take action averages over 69,000 visitors per month.
- As of August 2024, CMS has returned **more than $1.7 million in restitution** to consumers and providers for violations of the No Surprises Act.
- CMS has also answered thousands of questions from consumers who reached out to the No Surprises Help Desk for information about their medical bill rights.

Streamlining prior authorization and information exchange

CMS in 2024 finalized the **CMS Interoperability and Prior Authorization final rule**, which will improve electronic data exchange and streamline prior authorization of care in Medicare Advantage, Medicaid and CHIP fee-for-service and managed care, and Marketplace plans – leading to more timely access to health information and medically necessary care.

- In that rule, CMS requires impacted payers to adopt certain technology to exchange patient health data.
- The rule also requires Medicare Advantage organizations, and Medicaid and CHIP agencies and managed care organizations, to make prior authorization decisions within 72 hours for expedited requests and seven days for standard requests.
- This will reduce provider burden, allow **physicians more quality time with patients, ensure patients get the care they need, and save about $15 billion** in administrative costs over 10 years.
- Under a separate rule, CMS requires Medicare Advantage plans' prior authorization policies to ensure people with Medicare Advantage get access to the same medically necessary care they would receive in Traditional Medicare.

Improving hospital price transparency to make care more shoppable

CMS continues increasing and enforcing price transparency of hospital standard charges. The hospital price transparency rule requires hospitals to make all their standard charges public, including certain standard "shoppable" health care services. Hospitals must post the shoppable service charges in a consumer-friendly online display and all standard charges in a machine-readable format.

- As of July 2024, **CMS has issued more than 1,300 warning notices and more than 800 requests for Corrective Action Plans.**
- CMS imposed nearly $4.9 million in monetary penalties on 15 hospitals for noncompliance. Penalty notices are made publicly available on the **CMS hospital price transparency website**. CMS helps hospitals come into compliance by offering technical assistance.
- CMS strengthened and streamlined enforcement capabilities to promote compliance and increase transparency.

$4.9M

Penalties imposed for noncompliance with hospital price transparency rules

Holding emergency rooms accountable and reducing barriers

Everybody has a right to emergency care, regardless of health insurance status, ability to pay, citizenship, race, color, national origin, sex, religion, disability, or age. Under the **Emergency Medical Treatment and Labor Act (EMTALA)**, Medicare-participating hospital emergency departments are required to screen individuals for an emergency condition, and if an emergency condition if found, the hospital must stabilize the condition, or, if needed, transfer the individual to another hospital with specialized capabilities and staff that can provide the stabilizing treatment.

- In 2024, CMS created a simple web form that makes it easy to **file a complaint** if anyone believes a hospital has failed to meet EMTALA requirements.
- This will help hold hospitals accountable for the care they provide in emergency rooms.

Extending coverage

DACA recipients

In 2024 CMS finalized a rule to **allowing Deferred Action for Childhood Arrivals (DACA) recipients to enroll in a health plan** through the Health Insurance Marketplace or Basic Health Program. CMS estimates that this rule could lead to 100,000 previously uninsured DACA recipients enrolling in health coverage, helping advance the Administration's commitment to ensuring affordable, quality health care for all.

COFA migrants

The agency provided **guidance** to state agencies to extend Medicaid eligibility to the citizens of the Freely Associated States living in the United States under the Compacts of Free Association (COFA). As of March 9, 2024, states and the District of Columbia are required to provide CHIP coverage to COFA migrants who meet the requirements. Medicaid coverage must already be provided to eligible COFA migrants under previous requirements.

Afghan evacuees and Ukrainian nationals

In 2021, the agency provided guidance to state agencies regarding the availability of health coverage through Medicaid, CHIP, the Health Insurance Marketplace, and Refugee Medical Assistance or other health coverage provided by the Office of Refugee Resettlements to **Afghan evacuees** and certain **Ukrainian nationals** in the United States.

Providing care to previously incarcerated people

CMS took decisive action under Medicare and Medicaid to ensure that **essential health care is extended to incarcerated individuals**.

- The agency created new **special enrollment periods** for Medicare Part B (and people who pay a premium for Part A) for previously incarcerated individuals, ensuring access to needed coverage and care. A proposed **revised definition of "custody"** would also result in coverage expansion.
- The agency provided new state flexibilities to use Medicaid and CHIP funds for certain **pre-release health care to incarcerated individuals** to help them succeed and thrive during re-entry. As of August 2024, CMS has approved reentry demonstrations in 11 states.
- CMS released a resource to connect people leaving incarceration to health care services. **Returning to the Community: Health Care After Incarceration: A Guide for Health Care Reentry,** a joint publication of CMS and the U.S. Department of Justice, is available in nine languages on the **Coverage to Care website**.

Cracking down on junk insurance to ensure quality coverage

CMS, working with the Departments of Labor and Treasury, issued rules to **protect consumers from junk insurance plans** not subject to many of the Affordable Care Act's critical consumer protections. These "short-term" plans, sometimes sold using dubious marketing practices, may not cover essential benefits like prescription drugs, exclude coverage for pre-existing conditions, or impose annual or lifetime dollar limits on services. The rules ensure that these plans are truly used only in the short term to fill temporary gaps in comprehensive coverage.

Engage Partners

CMS has continued to engage with partners and the communities we serve throughout the policymaking and implementation process. During this Administration, **CMS leadership has participated in over 3,000 engagements with a variety of stakeholder organizations**, and teams around the agency have connected with hundreds of groups of states, health care clinicians and providers, health plans, consumers and consumer groups, manufacturers, other government entities, and thought leaders. Some of our most important areas of stakeholder engagement over the past four years follow.

COVID-19

During the COVID-19 pandemic, CMS reached over 158 million people with educational information through listening sessions, publications, email communication, and social media. CMS also worked with national stakeholders to spread awareness about the CDC COVID-19 vaccine communication toolkit, which reached over 40 million people.

Medicare drug costs

Following passage of the Inflation Reduction Act, CMS took action to engage thousands of partners about the many changes to Medicare Part D brought about by this historic legislation. From 2022 to 2024, CMS highlighted the IRA on 12 national calls with over 32,000 attendees on Medicare drug changes, and conducted 102 in-person and virtual trainings. **Partners used CMS resources to reach over 708,000 consumers**.

32K

Attendees on calls about Medicare drug changes under the Inflation Reduction Act

- In 2022, CMS swiftly addressed the commitment to transparency by holding six listening sessions with partners from across the healthcare landscape, including biotech organizations, health plans, manufacturers, patient advocacy organizations, and provider groups.
- In 2023, CMS held 10 patient-focused listening sessions on each of the prescription drugs selected for Medicare Drug Price Negotiation. For the first time, patients, providers, and advocates had the opportunity to share feedback on the Medicare Drug Price Negotiation Program directly with CMS leadership in real time.
- As of August 2024, CMS has sent 77 listserv messages to an audience of over 220,000, providing updates on key milestones of the prescription drug law.

Medicaid renewals

In the spring of 2023, when regular Medicaid and CHIP renewals restarted for the first time in three years following the COVID-19 pandemic, CMS faced a unique and urgent challenge to help eligible individuals keep their Medicaid and CHIP coverage and, for those no longer eligible, transition to other forms of coverage. CMS engaged partners across the public and private sectors to help people stay covered.

- Between 2022 and 2024, CMS hosted **30 webinars to share information about the Medicaid/CHIP renewal process**, outreach best practices, and educational resources with 68,000 people from national and local groups. CMS helped fulfill 95 speaking requests and reached over 10,000 people through partner-hosted events.
- To address health equity, **CMS created targeted information about Medicaid and CHIP renewals for underserved populations**, including Asian Americans, Native Hawaiians, and Pacific Islanders; Blacks and Latinos; people with disabilities; rural residents; and American Indians and Alaska Natives. A webinar series was held in summer 2023 for partners working with each population to share outreach strategies and best practices, reaching nearly 8,000 organizations.
- CMS **collaborated across the federal government** to get the word out on Medicaid and CHIP renewals. For example, in 2023 CMS partnered with the United States Postal Service to run informational videos about Medicaid/CHIP renewals in over 4,000 post offices. In 2024, CMS partnered with the Internal Revenue Service to share information with IRS field offices.

Marketplace Open Enrollment

Between 2021 and 2024, CMS held over 20 webinars about Marketplace Open Enrollment, educating nearly 6,500 stakeholders. **Partners used information from webinars and listserv messages to reach over 117 million consumers about enrolling in health coverage**.

117M

Consumers reached by partners engaged by CMS in support of Marketplace Open Enrollment, 2021-2024

- Communications included information about increased premium tax credits made possible by both the Inflation Reduction Act and the American Rescue Plan.
- These efforts contributed to enrollments that increased every year, resulting in a record 21 million enrollments in 2024.

Marketplace plan design and display

Between 2022 and 2024 CMS hosted a series **37 calls with representatives of 76 partner organizations to inform CMS decision-making on standardized plans designs, pre-deductible coverage, Silver plan forfeiture, and plan display** on HealthCare.gov. Groups included agents and brokers, health plans, state-based exchanges, navigators and assisters, consumer advocates, direct enrollment partners, and health plans.

Medicare Open Enrollment

CMS partnered with national stakeholders over the Medicare Open Enrollment Period from 2020 to 2024 to distribute information, **reaching a total of 139.4 million individuals**. This included work for the 2024 Open Enrollment Period, when changes to drug coverage created new challenges for partners to communicate benefit information to consumers.

Surprise bills

Between December 2021 and August 2024, CMS held **more than 100 webinars to educate consumers, advocates, health care providers, and health insurers about the new consumer rights and protections established by the No Surprises Act**. This included a series of five consumer-facing webinars hosted by CMS regional offices in partnership with the Public Interest Research Group, which taught consumers how to use the new **CMS Medical Bill Rights website** to get help with surprise bills and other medical bill problems.

100

Number of webinars held to educate stakeholders about new rights and protections of the No Surprises Act

Organ transplants

In 2023, CMS officially launched the **Organ Transplantation Affinity Group**, engaging with partners at the Health Resources and Services Administration. This collaboration seeks to drive improvements in organ donations, clinical outcomes, system improvement, quality measurement, transparency, and regulatory oversight.

Quality Conference

CMS hosted the **2024 Quality Conference,** attracting more than 5,000 health care leaders from across the country to explore how best to develop and share solutions to address America's most pervasive health system challenges. This year's meeting was a return to an in-person conference following the end of the COVID-19 Public Health Emergency.

Conference on Optimizing Healthcare Delivery

CMS held the inaugural **CMS Conference on Optimizing Healthcare Delivery to Improve Patient Lives.** The conference, which included a forum for over 2,500 attendees, identified successful solutions and best practices for reducing avoidable administrative burden and improving patient care delivery and clinician wellness.

Drive Innovation

As of 2024 there are 37 active models and initiatives being tested under the CMS Innovation Center; nine have been announced between 2022 and 2024. Across the agency there are other significant efforts to innovate in order to execute the agency's mission.

Innovating through value-based care

Alternative payment models reward health care providers for delivering patient-first, high-quality, affordable care, sometimes known as "value-based care." Several models introduced during this Administration have been presented earlier in this report: Transforming Maternal Health, Innovation in Behavioral Health, and the Cell and Gene Therapy Access Model. Other models include:

Dementia care

In 2024 CMS **announced the GUIDE Model** to improve the quality of life for people living with dementia, reduce strain on their unpaid caregivers, and help people living with dementia stay in their homes and communities.

- The model is the **first CMS effort to focus on longitudinal, condition-specific comprehensive care**. It links payment with care quality and works to address equity in care.
- With **390 participating organizations serving hundreds of thousands of people with Medicare**, the model delivers on President Biden's Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers.

390

Participating organizations in the GUIDE Model, which aims to improve quality of life for people with dementia and their caregivers

Primary care

A strengthened primary care infrastructure can produce better access to high quality care, resulting in better and more equitable health outcomes. In 2023 CMS announced the **Making Care Primary (MCP) Model**, a 10.5-year program that aims to improve care for people on Medicare and Medicaid in eight states by supporting:

- better care management and coordination;
- tools to help clinicians partner with specialists; and
- community connections to address patients' health and related social needs, including housing and nutrition.

In July 2024, CMS also announced the first three states participating in the 11-year **States Advancing All-Payer Health Equity and Development (AHEAD) Model**, which aims to improve the total health of a state population and lower costs, largely by strengthening primary care and care coordination. It provides funding to states that work to curb cost growth, improve outcomes, and advance equity.

Value-based, accountable care

In 2021, CMS established the bold goal of having all people with Traditional Medicare, and the vast majority of people with Medicaid, in an **accountable care relationship** with their health care provider by 2030. We continue to make progress toward that goal.

In Accountable Care Organizations (ACOs), groups of health care professionals take responsibility for giving patients high-quality, coordinated care, improving outcomes, and managing costs. Patients whose providers participate in ACOs experience greater care coordination, which can help reduce emergency department visits and hospital stays. ACOs have generated savings for the Medicare Trust Fund.

- **In 2024 there are about 13.7 million people with Traditional Medicare aligned to an ACO**, a 3 percent increase over 2023. More than 700,000 health care providers and organizations participate in three CMS accountable care initiatives. ACOs serve nearly half of people with Traditional Medicare.
- In 2024 CMS announced that 19 new ACOs in the Medicare Shared Savings Program are participating in a new option enabling them to receive more than $20 million in advance payments for caring for underserved populations, an important contribution to the agency's drive toward health equity. An additional 50 ACOs are new to the program in 2024, bringing the total to 480 ACOs in the Shared Savings Program.
- In 2022 the agency announced a comprehensive **strategy to support value-based, person-centered specialty care**. Specialty models include 2022's **Kidney Care Choices** model, to reduce the cost and improve the quality of care for patients with late-stage chronic kidney disease and ESRD, and the 2023 **Enhancing Oncology Model,** which supports President Biden's **Cancer Moonshot**.
- The **ACO REACH model**, which increases enrollee access to accountable care organizations, particularly in rural facilities, **grew from 53 ACOs and about 350,000 covered lives in 2021 to 132 ACOs and 2.1 million covered lives in 2023**.

2.1M

covered lives in the ACO REACH model, 2023, up from 350,000 in 2021

Post-surgical care

People who undergo a surgical procedure may experience fragmented care that can lead to complications in recovery, avoidable hospitalization, and increased spending.

- The **Transforming Episode Accountability Model (TEAM)** will **help people with Medicare receive coordinated, high-quality care during and after certain surgical procedures**.
- The model's goals include reducing hospitalization and recovery time, driving equitable outcomes, and lowering Medicare spending.

Access to medical advancements

In 2024, the agency finalized the **Transitional Coverage for Emerging Technologies (TCET)** Pathway, to **help people with Medicare access the latest medical advances**. The initiative enables doctors and other clinicians to provide the best care for their patients, and benefits manufacturers who create innovative technologies. With this initiative, CMS aims to improve the quality of life for people with Medicare while encouraging innovation.

Promoting innovation through coding and payment

New billing codes and payment updates in the Medicare Physician Fee Schedule in 2021-2024 move towards a health care system that recognizes each unique aspect of a person and their well-being, including physical health, behavioral health, oral health, social determinants of health, and caregiving support, with a foundation of primary care to integrate these components. In addition to helping people with Medicare get needed services, the availability of these new billing codes allows practitioners to get experience providing care critical to success as an ACO or another alternative payment model.

- In the **2024 Medicare Physician Fee Schedule**, CMS established new billing codes to allow practitioners to be paid for providing Principal Illness Navigation Services, Community Health Integration Services, Caregiver Training Services, and Social Determinants of Health Risk Assessment Services. CMS also **finalized a billing code that recognizes the importance, time, and effort required for clinicians to develop long-lasting, trusting relationships with patients**.
- The **2025 Medicare Physician Fee Schedule proposed rule** includes a proposal for Advanced Primary Care Management (APCM) codes that bring accountable care concepts into the Medicare program broadly. Building on lessons learned from Innovation Center models, these codes require practitioners to be responsible for all of the patient's primary care and demonstrate advanced primary care capabilities, while remaining accountable for performance measurements, like primary care quality.

Promoting innovation through quality improvement

In 2022 CMS refreshed its **National Quality Strategy**, an **ambitious, long-term initiative that promotes the highest quality outcomes and safest care for all people**, especially those in historically underserved and under-resourced communities.

- The strategy builds on previous efforts to improve quality across the health care system and incorporates lessons learned from the COVID-19 Public Health Emergency.
- It also addresses the urgent need for transformative action to advance towards a more equitable, safe, and outcomes-based health care system for all individuals.

Alignment of quality across programs

As part of its updated quality strategy, CMS is taking action to **align quality programs, initiatives, and measures across CMS programs**, including Medicare, Medicaid, the Marketplace, and private issuers.

- This alignment will result in higher quality care for the more than 170 million Americans covered by CMS programs, by focusing provider and health care system attention on high-priority clinical and support services; **streamlining measure development and selection**; and collaborating with partners and other payers across the nation for greater impact.
- Alignment across all CMS quality programs will lead to better quality care throughout a person's care journey — from infancy to adulthood — and for important care events, such as pregnancy and end-of-life care.
- Alignment of CMS quality efforts across other priorities, such as the levers and initiatives used to advance health equity, will amplify and increase the impact of our efforts on the American people.

Protect Programs

CMS is focused on protecting programs for future generations by serving as a responsible steward of public funds. The agency identified innovative solutions and took bold action during this Administration to protect program sustainability and lower the risk of harm to people enrolled in Medicare, Medicaid, and Marketplace coverage. *(All data are for fiscal years.)*

Protecting program integrity

From 2020 through 2022, **CMS program integrity activities saved Medicare an estimated $39.3 billion**, producing an overall return on investment of $7.70 for every $1 spent. During that period collaborative federal-state program integrity efforts for Medicaid and CHIP produced savings of an estimated $6.2 billion.

Catheter fraud crackdown

In early 2023, CMS identified a concerning rise in urinary catheter billings which was attributed to a small group of durable medical equipment (DME) supply companies.

The agency quickly took action to prevent Medicare from paying for these fraudulent claims, preventing over 99% of the payments for the fraudulent Medicare payable claims from being issued to 15 fraudulent suppliers. These suppliers were responsible for over 89% of over $4 billion in Medicare billings for urinary catheter supplies from January 1, 2023 to July 6, 2024.

99%

Fraudulent urinary catheter claims prevented from being paid due to fast agency action

- CMS is working closely with law enforcement to support investigations and ensure individuals and companies are subject to civil and criminal penalties if appropriate.
- In addition, CMS revoked Medicare enrollments of the 15 suppliers. Revocations prevent the supplier from re-enrolling in Medicare for up to 10 years.
- CMS and its contractors have used the lessons learned to improve monitoring and response.

Hospice risk mitigation

Patients enrolled in hospice care are especially vulnerable to fraud. In July 2023, CMS implemented a Provisional Period of Enhanced Oversight (PPEO) on newly enrolling Medicare hospices and those undergoing a change of ownership in four states: Arizona, California, Nevada, and Texas. Hospices covered by the PPEO are subject to prepayment medical review that looks for many of the problematic activities recently seen in the hospice community, like providers billing for patients who don't meet hospice eligibility criteria.

- There has been a **65% decrease** in new hospice enrollments in the year since the PPEO started.
- As of August 7, 2024, 434 providers have been subject to PPEO. Forty-four providers, or about 10%, have been revoked based on medical review results. CMS has revoked 14 providers based on an affiliation to a PPEO provider that poses an undue risk of fraud, waste, or abuse.

- As part of CMS' national site visit project, 6,785 hospices were visited. Forty-eight hospices have had their Medicare enrollment revoked. This means they are barred from the Medicare program for between one and 10 years. An additional 478 hospices have had their Medicare billing privileges deactivated, meaning they are unable to bill Medicare.

Decrease in Medicare Fee-for-Service (FFS) improper payments

In 2023, the Medicare **FFS estimated improper payment rate was below the 10% compliance threshold for the seventh consecutive year**.

- The Medicare home health improper payment rate decreased from 9.30% percent in 2020 to 7.78% in 2023, representing a $507 million decrease in projected improper payments.
- The durable medical equipment improper payment rate decreased from 31.80% in 2020 to 22.51% in 2023, representing a $823 million decrease in projected improper payments.

$823M

Decrease in projected improper payments for durable medical equipment, 2020-2023

Reduction in Medicare Advantage overpayment estimate

- CMS achieved a **reduction in the Medicare Advantage overpayment estimate** from 6.7% in 2021 to 5.32% in 2023, representing a $600 million decrease in projected overpayments.

Cracking down on COVID-19 fraud

CMS **prevented significant payments to suppliers who attempted to defraud Medicare by billing for COVID-19 over-the-counter test kits** that were not requested or provided. CMS is continuing to assist law enforcement as they investigate and prosecute those who exploited this benefit during the pandemic.

Holding Medicare Advantage insurers accountable

In 2023, CMS finalized important rules used to identify and recover excess **payments made to Medicare Advantage plans**. These rules address instances where Medicare pays the plans more than they should receive based on the medical diagnoses in the medical record.

- Audits show billions of dollars in overpayments and increased costs to the Medicare program.
- This commonsense policy ensures that the nearly 30 million people covered by Medicare Advantage plans get the benefits and services they need while protecting the financial sustainability of the Medicare program.

Protecting Marketplace consumers from bad actor agents and brokers

In 2024 CMS took decisive action to **protect Marketplace consumers from agents and brokers who might try to enroll them or change plans without their knowledge**.

- After receiving over 200,000 complaints in the first half of 2024 about unauthorized Marketplace enrollments or changes, CMS put new procedures in place to block those actions. The agency has resolved about 97% of them, and continues to work to resolve the rest.
- CMS has suspended more than 500 agents and brokers from participating in the Marketplace, and engaged in social media outreach to educate consumers on the topic.

Foster Excellence

CMS is committed to promoting excellence in all aspects of CMS operations and fostering a positive and inclusive workplace and workforce.

Using data to drive decision-making

In 2022, CMS established a cross-cutting initiative to **ensure that policy decisions are driven by high-quality data**, and to drive innovation and person-centered care through data exchange. The agency developed a set of **Data Principles and Operating Norms** that represent a shared set of values.

- This provides a foundation for supporting data-driven decisions across the agency.
- CMS has established workgroups and developed action plans to change culture, policies, processes, and contracts to help the agency adopt the principles.

Integrating Human-Centered Design across the agency

During the last four years CMS has continued to **integrate Human-Centered Design in its program improvement efforts**, as a way to ensure that the voices of the American people, and the needs of the people it serves, remain at the center of agency policies and programs. This process includes participatory design, where the agency works directly with clinicians, patients, vendors, federal partners, and CMS employees to understand the context of the work and potential solutions.

CMS' human-centered initiatives have gleaned over **35,000 data points from speaking directly with over 20,000 research participants**. CMS human-centered design engagements include those related to chronic pain, prior authorization, behavioral health, oral health, national directory, clinicians, and U.S. Island Territories.

20K
Research participants in CMS human-centered design engagements

These human-centered projects undertaken in 2022 addressed some of the agency's top priorities.

- CMS conducted an **Accountable Care Organization (ACO) Human-Centered Design Customer Engagement** in order to understand barriers to providers' reporting data critical to ACO participation.
- The agency conducted the **Oral Health Human-Centered Design Customer Engagement** to understand the barriers to oral health access faced by Medicaid or dual (Medicaid-Medicare) eligible children and adults. This supports the agency's Oral Health Cross-Cutting Initiative and equity goals.
- CMS posted a Request for Information, titled **Make Your Voice Heard**, seeking public insights and recommendations on barriers to accessing care and related challenges. Over 4,000 comments were received, providing invaluable insight into how our work supports stakeholders and how health care can be improved.

Infusing a customer-centric mindset across the agency

Over the last four years CMS has **transformed how the agency identifies and addresses the needs of the people we serve**. Through the Beneficiary and Consumer Experience (BACE) program the agency has:

- established new frameworks, cross-functional teams, and forums for translating insights about the beneficiary and consumer experience into policy and process decisions;
- leveraged new customer feedback loops and listening channels to address key touchpoints in the moments that matter most; and
- matured customer experience training and development to provide employees with the tools they need to build empathy, develop customer data literacy, and measure factors that underpin trust and satisfaction.

Streamlining public health data reporting

Building on lessons learned from the COVID-19 pandemic, CMS finalized a **permanent streamlined data reporting structure for COVID-19, influenza, and respiratory syncytial virus (RSV)**.

- This includes additional reporting requirements that could be activated in the event of a declared public health emergency.
- This reporting will help ensure that hospitals and the health care system have the appropriate insights related to evolving infection control needs.

Improving cyber-resiliency

Over the last four years CMS has strengthened its cybersecurity posture by implementing emerging industry best practices, improving security processes, and building new foundational capabilities that help protect our systems and data against cyberthreats.

Increasing resiliency of the CMS software supply chain

In response to the **President's Executive Order on Improving Cybersecurity**, in 2021 CMS took decisive steps to improve the resiliency of the CMS software supply chain. The agency has done this by incorporating the best practice of system composition analysis enterprise-wide, identifying vulnerabilities throughout the software development lifecycle, from development to deployment. **This has led to improved identification and resolution of vulnerabilities and risks**.

Centralizing security data management

In response to an **Executive Order** and **OMB guidance** directing cybersecurity improvements and adoption of a zero trust strategy, CMS built the Security Data Lake. This central data repository provides **real-time visibility and access to cybersecurity information** and analytical tools, including artificial intelligence. This better protects the agency against risks and cyberthreats.

Supporting improved cyber resiliency in the health care sector

In the last two years, as cyberattacks in the health care sector have increased, CMS has taken a proactive role in advocating for improved national health care cyber resiliency across the Healthcare and Public Health (HPH) Sector by encouraging all providers of services and suppliers, technology vendors, and other members of the health care ecosystem to double down on cybersecurity, with urgency.

- CMS has helped to develop and promote the Department's **HPH Cybersecurity Performance Goals**.
- The agency created a Cybersecurity Threats and Resource Brief that explains the threats the sector faces and pulls together available resources into one place. Downloadable resources are available at the **Homeland Security Threats Quality, Safety & Oversight Group - Emergency Preparedness General Guidance website**.

Innovating agency operations with artificial intelligence

Recognizing both the potential power of AI and the government's need to responsibly harness its capability, CMS has been moving forward with several initiatives to position the agency for the future.

- **The agency has completed 23 AI trials and proofs of concept, and another 14 are active**. CMS is supporting "bite-sized" experiments to spur low-risk innovation across the agency.
- A new **AI cross-cutting initiative** has been established to provide strategic coordination and ensure the agency integrates AI technology into our operations while protecting security and privacy and mitigating bias. The group is exploring rules and standards in the use of AI in the health care sector.

Maintaining a "Clean" audit opinion

CMS has maintained an unmodified **"clean" audit opinion for the last 25 years.** This means the auditor has found that financial statements are presented in accordance with U.S. generally accepted accounting principles.

Building diversity, equity, and inclusion

- CMS has implemented the diversity, equity, and inclusion (DEI) Basics Course. As of July 2023, **85% of all CMS managers had taken this course**. All new employees and managers take this course as a mandatory part of their New Employee Orientation.
- CMS has **44 initiatives across the agency that will improve diversity, equity, inclusion, and accessibility**, half of them completed in the past two years.
- The DEI **Ambassadors Program has 96 CMS employees across 26 components** serving as dedicated advocates and champions for DE, by fostering a culture that values the unique perspectives, backgrounds, and experiences of all staff, amplifying marginalized voices, promoting trust and consistency in CMS's DEI initiatives, and acting as catalysts for positive change.

44

Number of initiatives across the agency that will improve diversity, equity, inclusion, and accessibility

Keeping CMS a "Best Place to Work"

CMS ranks in the top 30% of "Best Places to Work" among federal agencies as measured by the Federal Employee Viewpoint Survey and the Employee Engagement Index. **The agency ranks in the top 20% for work-life balance.**