Centers for Medicare & Medicaid Services
Leadership National Call Update
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Eden Tesfaye: Thank you so much for joining us today for our fourth and final Centers for Medicare and Medicaid Services (CMS) Leadership National Call of 2024. I'm going to walk through today's agenda and then turn things over to our speakers. But before I do that, I have a couple of housekeeping items. This call is being recorded. For those who want to use American Sign Language, also known as ASL, select the round 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 welcome to attend the call, please note that all press/media questions should be submitted using our media inquiries form, which may be found at CMS.gov/newsroom/media-inquiries. We will not be answering questions during the call. Everyone should be able to see today's agenda on their screen. We have a full agenda that includes our fearless leaders—CMS Administrator Chiquita Brooks-LaSure and her phenomenal leadership team—who will highlight CMS' accomplishments over the last several years under this administration. Our leadership team speakers will include Principal Deputy Administrator and Chief Operating Officer Jon Blum, along with our Deputy Administrators who lead the different centers at the Centers for Medicare and Medicaid Services. And one last note that I'd like to make sure you guys are aware of. We have a slight change to our agenda. Our Principal Deputy, Jon Blum, will be kicking off the call, and we will have closing remarks from CMS Administrator Chiquita Brooks-LaSure. So, with that, I'll turn things over to our Principal Deputy Jon Blum. Jon, over to you.

Jonathan Blum: Thank you, Eden, and thank you for all who have joined us today. Before turning it over to our policy leadership team, who are phenomenal, I want to spend some time highlighting some of the quiet changes that have happened here at CMS during the past several years. I want to start by saying that CMS today is stronger than ever. We have focused deeply on our operational footprint to ensure the health care system works well. CMS programs work well, and I couldn't be prouder about some of these changes. I want to highlight several things for the group today. Number one is that those who tracked CMS carefully during the past 12 months knew that certain parts of the organization were under a severe hiring freeze. That is no longer the case. Due to some very hard work, we have turned the CMS financing systems around and are very proud to say that CMS is now back to hiring. We are really proud of the work that we did to get our house to be able to invest again and to begin to hire again.

Despite some of the challenges we've had with funding and hiring over the past several years, we have built phenomenal teams. We have new teams who are negotiating drug benefits, for example, and we've added to our ranks with members of the CMS senior leadership team. In 2024, we added 14 new individuals to lead CMS through the career leadership team. Our contracts and grants teams have never been busier. During fiscal year 2024, CMS took 3,800

separate contract actions. These are very complicated contracts, and our contracts teams are doing phenomenal work to ensure CMS programs work well. We've taken strong steps to make sure CMS programs, and those we assist, are far better prepared to handle disasters, pandemics, and cyberattacks. For example, in 2024, we learned key lessons about how to prepare, prevent, and support health care providers through disruptions, whether from cyberattacks, natural disasters, or other challenges to the health care system. We've also adjusted policy environments to create stronger incentives for health plans and health care providers to do everything they can to prevent disruptions.

In the area of health care cyberattacks, CMS provided $3 billion in direct financial support to health care providers participating in the Part A and Part B programs—and CMS got all of that money back, which is a huge accomplishment. From 2021 to 2024, CMS built new claims systems that, for the first time, allowed us to pay dental providers directly. This is another significant accomplishment. We've also prepared the agency to lead in how we think about, regulate, and pay for new technologies and innovations, including artificial intelligence. CMS will continue to lead the way in these areas. We've made significant improvements in how we share and produce data to ensure our system, the VRDC (Virtual Research Data Center), remains the gold standard for sharing data with health care researchers. CMS programs have also become much easier to navigate. By applying customer service and human-centered design approaches, we've worked to ensure CMS is the best possible payer and insurer. We've set higher standards for how the health care system should operate, including creating stronger requirements for how prior authorization systems should function. The CMS actuary team continues to be best in class, producing the top-quality estimates that are the foundation for all CMS policy development. These accomplishments show the significant progress we've made to strengthen CMS and lead the way forward.

Finally, we have changed the way we engage with you, with health care stakeholders, to ensure that we're getting out into the country far more, to ensure that we're seeking out those who have critical voices to ensure that CMS programs work better to ensure they cover more people, to ensure that we're listening to those who are the underheard, the underserved. We could not be prouder of the whole CMS team. There are more than 6,400 people who work here at CMS, far more contractors and I could not be prouder of the accomplishments and the work that we've seen during 2024 and during the past four years. And with that, we'll turn it over to our first speaker. Meena, the floor is yours.

Dr. Meena Seshamani: Thank you so much Jon, and thank you to all of you for being here with us today. I am Dr. Meena Seshamani, Director of the Center for Medicare, and it has been an honor and the privilege of a lifetime to work with all of you leading the Center for Medicare. For more than three years, our team has worked toward an ambitious vision for Medicare driving health equity, expanding access, focusing on patient-centered care, and promoting affordability and sustainability in partnership with all of you. In everything that we do, we keep the people we serve at the center of our work. And because of all of this, Medicare is better than ever, and people with Medicare continue to have affordable and high-quality choices across traditional Medicare, Medicare Advantage, and Medicare Part D prescription drug coverage.

Starting with traditional Medicare, numerous policies will drive the entire health care system towards caring for people rather than just treating a diagnosis code. For example, starting in 2025, Medicare will have a bundled payment for advanced primary care management, which will support practitioners to provide high-quality, person-centered care. We have also made several changes to increase participation in the Medicare Shared Savings Program, particularly for ACOs (accountable care organizations) working with rural and underserved communities. Year over year the Shared Savings Program continues to save Medicare money while supporting high-quality care. In 2023 alone, it yielded more than $2.1 billion in net savings to Medicare, the largest in the program's history. We are also rewarding health care organizations across traditional Medicare and Medicare Advantage plans that provide excellent care for underserved populations. We advanced policy for the first time ever to allow Medicare to pay for community health integration services, care navigation, peer support, and caregiver training, all of which are particularly needed in underserved communities. We finalized policies that improve access to behavioral health care from creating a new benefit, the intensive outpatient program, to enabling licensed marriage and family therapists and licensed mental health counselors to enroll and bill in Medicare, to new graduate medical education slots, making tele-behavioral health permanent and strengthening behavioral health access standards in Medicare Advantage.

Speaking of Medicare Advantage, we've implemented several pragmatic policies in Medicare Advantage around prior authorization, utilization management, marketing, language access, and payment accuracy. We repeatedly heard concerns with accessing medically necessary care in a timely manner and the burden that this places on providers. To address this, we've taken significant action to reform prior authorization and utilization management. These policies are life-changing for beneficiaries who can now rest assured that they will continue to have streamlined access to the care they need. We also heard repeatedly about concerns with misleading marketing practices. We know that without accurate information, people with Medicare cannot make the best choices for themselves. So, we put in place beneficiary protections through our recent regulations to address misleading marketing practices. As a result, we've rejected more than 1,000 television ads that were found to be misleading. CMS is also implementing iterative enhancements to the MA (Medicare Advantage) and Part D star ratings program to promote continual quality improvement to help ensure that enrollees receive high-quality care and to incentivize plans to continue to strive for higher quality.

Medicare has been at the forefront of expanding language access as well. 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. We also now require Medicare Advantage plans to provide communications in any language that more than 5% of their enrollees speak. CMS has also made common-sense updates to the Medicare Advantage risk adjustment model to increase payment accuracy, which is especially important given that Medicare Advantage is estimated to cost $7 trillion over the next 10 years. Payment accuracy is vital to our efforts to drive competition on what matters and to support accountable care because it shifts the emphasis to truly managing care and improving outcomes, complementing our other efforts to raise the bar on quality standards and to push plans to continually improve. Our goal is for the Medicare Advantage market to compete on things that matter most to enrollees—things like affordability, management of chronic conditions, access to world-class providers, and innovative approaches to care delivery.

As the recently published Medicare Advantage and Part D landscape demonstrates, improving payment accuracy in this common-sense way continues to support stability in premiums choice and benefits in the market while spending the Medicare dollar where it is needed most to provide care for Medicare beneficiaries. A signature milestone in advancing affordable coverage is the historic change we've made to prescription drug coverage in Medicare Part D. Starting January 1, all people enrolled in Medicare Part D will have their out-of-pocket prescription drug costs capped at $2,000 per year—the first time in the history of the Medicare program that there has been a cap on what people will pay out of pocket for their covered prescription drugs. These new benefits build on the $35 cap on cost sharing for a month's supply of covered insulin, $0 cost sharing for recommended vaccines under Part D, and expanded financial assistance in paying for drug costs through the Extra Help Program.

Finally, the successful negotiation of the first 10 drugs of the Medicare Drug Price Negotiation Program will lead to an estimated $6 billion in savings in its first year alone, marking a landmark milestone in affordability and sustainability for Medicare. Through ongoing engagement with drug manufacturers, patients, clinicians, health plans, and others, our common goal was clear—improving access to the innovative cures and treatments people need at a price they can afford. These negotiations were a true back and forth based on data around the real world clinical benefit of the selected drugs, alongside other data on costs of research and development and costs of production and distribution. Approaching negotiations in this way struck a balance between innovation and fair prices for people with Medicare and the Medicare program, leading to what we envision as a stable negotiation program now and into the future. But again, none of the incredibly impactful changes that we have made to the Medicare program these past three years would have been possible without close partnership and input from all of you. We ensured that we provided as many opportunities as possible to hear directly from you so that we could have a full understanding of the impact of our work. And successful implementation has in turn relied on these partnerships to make sure that we are together having an impact for individual people in their communities. Collectively the improvements we have made to Medicare in just four years are truly historic and meaningful for people with Medicare, their families, and their caregivers. They create a foundation to drive further thoughtful and innovative approaches across the whole care ecosystem. So again, thank you for joining today, and I'll now pass it on to Dan Tsai. Dan.

Dan Tsai: Thank you, Meena. Good afternoon, or good morning, to everyone on the call. It’s truly a privilege and an honor to be part of this team and this administration. I’m very grateful for the opportunity to work alongside such dedicated colleagues, and I’m excited to be here with all of you today. We’re at an unprecedented crossroads for Medicaid, and it’s an exciting time to be part of this work. I’m Dan Tsai, the Medicaid Director at CMS, and the Federal Medicaid Director. Medicaid, along with the Children’s Health Insurance Program (CHIP), plays a critical role in our health care system. Medicaid is the bedrock for coverage across the country—over one in five Americans rely on us for their health care. We cover half of all children in the U.S., and the majority of people we serve are working families. For those without Medicaid coverage, the families are often forced to make tough, sometimes heart-wrenching, decisions about what they can afford when it comes to their children's health.

We are leaving the program much stronger today than it was four years ago, but that progress is at risk. Proposals such as adding work requirements for Medicaid or implementing block grants would introduce burdensome red tape—requirements that none of us would accept for ourselves when accessing health care or any good or service, whether in the public or private sector. Policies like work requirements and block grants are simply bad policy. They're not supported by facts or evidence, and their cost will be measured in people's lives and health across the country. With that in mind, it's important to recognize the significance of this moment and to reflect on everything we've accomplished over the past few years—together with so many of you in the community, including our states, providers, advocates, plans, and others across the country. Our focus is on health care coverage and access—treating health care as a human right and ensuring that people can access it and their providers without unnecessary hurdles or needing to be a rocket scientist to navigate the system. Under this administration, we have made fundamental improvements to how eligible individuals enroll in and renew their Medicaid coverage. This includes reducing administrative barriers and cutting the red tape that has historically made Medicaid challenging to navigate. We've also worked to ensure that states are following federal rules. I'm incredibly proud of the team, and the numbers reflect their hard work and success. Currently, Medicaid covers close to 80 million people—about 10 million more than before the COVID-19 pandemic. Overall, the number of people across the country with health care coverage, whether through Medicaid, other CMS programs, or employer-sponsored coverage, remains at historic highs. During the past year and a half of Medicaid redeterminations and renewals, we've made significant progress. By ensuring states comply with federal rules and implementing new policies, we've achieved tremendous improvements. For instance, our auto-renewal rates—the number of eligible people able to renew their Medicaid coverage through states accessing data sources—have doubled during this period.

Second, we've achieved significant nationwide coverage expansions under this administration. Nearly all states—46 states and Washington, D.C.—have extended postpartum coverage for mothers from just 60 days to 12 months. This is a tremendous improvement in maternal health and a critical step forward. Additionally, many states have expanded Medicaid, resulting in over 23 million people gaining coverage through Medicaid expansion under the Affordable Care Act. We've also expanded coverage for justice-involved individuals who are preparing to reenter the community, further ensuring access to essential health care services for more people.

Third, we've made real progress in keeping kids covered, which has led to better health outcomes for them. Through permanent regulatory changes, we've made it easier for eligible children to get and maintain their coverage. We've also supported states in offering more continuous eligibility for children and taken steps like banning waiting periods before kids can access health care coverage.

Finally, once people have coverage, we've focused a tremendous amount of time and effort on making it easier for them to access care. This includes regulations, policies, and a strong focus on Medicaid reimbursement for a wide range of providers, including mental health, behavioral health, and home and community-based providers. We've also implemented maximum appointment wait time standards for enrollees in managed care, which will be rolled out soon. These efforts span the full spectrum of medical services—physical health care, behavioral health care, and home and community-based services—ensuring that people have access to a network

of providers that reflects what the broader population has access to, in a timely manner, and in a way we would demand for ourselves. We're grateful for the immense partnership we've had with all of you. I could continue discussing the tremendous work and successes of the Medicaid program, but I'll pause here for time and turn it over to my friend and colleague, Ellen, with whom we've partnered on so many initiatives between Medicaid and the Marketplace. Ellen, over to you.

Dr. Ellen Montz: Thank you, Dan. It's an honor to continue updating all of you on our incredible progress across CMS, and specifically within my Center for Consumer Information and Insurance Oversight (CCIIO), where we manage the Affordable Care Act Marketplaces across the country. First and foremost, I'm excited to announce that we're in full swing with this year's Open Enrollment—our 12th Open Enrollment period on the Marketplaces. Thank you for all the work you do to connect people to coverage, which truly is lifesaving. Just a quick reminder: The deadline to sign up for coverage effective January 1 is December 15.

I want to take a moment to reflect on the tremendous achievements we've made together over the past few years. First, we've taken enrollment to new heights—from approximately 12 million in the 2021 Open Enrollment period to 21.4 million during last year's Open Enrollment period. We're optimistic about more good news this year as well. Last year's record-breaking Open Enrollment period underscored a key point that I often make—it's simple but true: If you make health care more affordable and you let people know it's available, more people will get covered. This is the essence of what's happened, and the impact has been profound. Throughout the Biden-Harris Administration, we've also focused on improving racial health equity and increasing access to affordable health coverage. This effort is reflected in the enrollment gains we've seen in the Marketplace, which have outpaced the average enrollment growth from previous years. During the 2023 Open Enrollment period, we doubled the number of Black and Latino enrollees since 2020—a significant accomplishment in just three years.

We are better positioned than ever before, with a combination of robust, easy-to-understand plan options on the Marketplace, improved consumer experience, large-scale outreach, advertising, enrollment assistance, and record affordability. I want to take a moment to highlight that record affordability. Thanks to the American Rescue Plan and the Inflation Reduction Act's enhanced subsidies, four out of five HealthCare.gov customers will be able to find health care coverage on the Marketplaces for $10 or less per month for 2025, following the increase in subsidies. These additional tax credits allow our customers across the Marketplaces to keep an average of $800 in their pockets each year. That could be money used to afford prescription drugs, contribute to a child's education, or meet other vital needs. This is $800 that stays in their pockets thanks to the American Rescue Plan and the Inflation Reduction Act subsidies—subsidies that unfortunately expire at the end of 2025. This is a crucial component of the affordability and success of the Marketplace.

Through our largest outreach and enrollment campaign, and with a significant investment in navigators, we've worked tirelessly over the past few years to ensure that communities historically uninsured or underinsured were informed about affordable coverage options and supported in enrolling in and utilizing those options. This is why we've recently issued $100 million in navigator cooperative agreements across 44 organizations. These grants are part of a

broader commitment of up to $500 million over five years, the longest grant period and financial commitment we've made to our trusted partners in the navigator community.

I also want to note the incredible work between the Marketplace, Medicaid, and CHIP to strengthen both programs by building stronger connections between them. This has helped us transition individuals across Medicaid and Marketplace programs more effectively. We collaborated with the Medicaid agency to manage the largest coverage transition since the Affordable Care Act. We remained laser-focused on our plan to mitigate coverage loss during the public health unwinding and ensured that individuals who were no longer eligible for Medicaid could transition smoothly to the Marketplace. We employed a Special Enrollment Period, enhanced account transfers between states and the Marketplaces, and supported direct outreach through our navigators to those who may have lost Medicaid coverage. As a result, we successfully transitioned over 2.4 million people from Medicaid to the Marketplace during the unwinding period.

When we shift focus from enrollment to consumer experience and the plans available on the Marketplace, we've worked tirelessly to enhance that experience. We've made significant improvements to HealthCare.gov, and I'm especially proud of the dramatic reduction in administrative friction—the barriers that made it feel like you needed a rocket scientist degree to sign up for coverage, as Dan mentioned. We've done incredible work in reducing these obstacles, and as a result, we've seen greater coverage gains. We've also focused on improving the content of the health insurance plans available on the Marketplace. We've implemented standardized plan options that provide more services before the deductible, making it easier for consumers to access care. Additionally, we've introduced new network adequacy requirements for health plans across the Marketplaces to ensure that appointment wait time standards and time-and-distance standards are met, which directly benefits consumers. Beyond the Marketplace work at CCIIO, we also collaborate with our colleagues at the Departments of Labor and Treasury to ensure that across the commercial market, consumers are protected and have access to the benefits they need.

I want to highlight a few key rules we've implemented over the past few years. First, we issued rules to protect consumers from "junk" insurance plans—those that are not subject to many of the Affordable Care Act's critical consumer protections. Recognizing that far too many Americans still struggle to find and afford the mental health care they need, we released new final rules expanding access to behavioral health care by implementing additional requirements for health plans under the Mental Health Parity and Addiction Equity Act. Following the Supreme Court's decision to overturn Roe v. Wade, we took several decisive actions. We issued 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. We also proposed rules to expand and strengthen access to birth control so that women who need it can obtain it at no cost.

Additionally, we released numerous guidance documents to ensure individuals are not improperly charged cost-sharing for any of the recommended preventive services under the Affordable Care Act. Over the last few years, CCIIO has been working closely with the Departments of Labor and Treasury to implement the No Surprises Act, which we are incredibly

proud to have rolled out. This law has already protected millions of patients and families from often crippling surprise medical bills.

Finally, we've taken critical steps to extend coverage to new populations under the Affordable Care Act. We finalized the Family Glitch rule, which extended coverage to families that may not have previously been eligible for tax credits. This past May, we also finalized a rule allowing DACA (Deferred Action for Childhood Arrivals) recipients to enroll in health coverage through the Marketplace. As we close out this year's 12th Open Enrollment period, I want to thank you again for your partnership. It's truly been an honor to serve our Marketplaces and the American people. I am incredibly proud of the work CMS and my center have done to fulfill and exceed the promises of the Affordable Care Act. Thanks to this work, people across the country are better able to live their lives to the fullest. With that, I will turn it over to Liz Fowler.

Dr. Elizabeth Fowler: Thank you so much. I really appreciate it. Good afternoon, everyone. I've served as Director of the CMS Innovation Center for about four years now, and I'm incredibly proud of all that we've achieved. I also share the sentiments of my colleagues—it's been a privilege to serve in this role and to work with people I consider not just colleagues but friends. It's truly been a tremendous and unparalleled opportunity. The role of the CMS Innovation Center is to test innovative models aimed at improving how we pay for and deliver care to individuals with Medicare, Medicaid, and CHIP. In the fall of 2021, we outlined a bold new vision for a health system that achieves equitable outcomes through high-quality, affordable, person-centered care. This vision, along with five strategic objectives and proposed metrics to track our progress, set the stage for the innovative models and initiatives we've announced and launched.

Central to our Innovation Center strategy is a focus on driving accountable care and advancing health equity. CMS has reinvigorated the movement toward accountable care by setting a goal to have 100% of traditional Medicare beneficiaries and a majority of Medicaid beneficiaries in accountable care relationships by 2030. In addition to this strong focus on primary care, I want to specifically highlight our strategic objective on health equity. We have committed to embedding health equity in every aspect of our Innovation Center models, with an increased focus on underserved populations. We have demonstrated this commitment to advancing the center's and the agency's health equity goals by taking real action with our new models. These efforts are focused on reaching beneficiary populations that have been underserved by our models in the past. We are also supporting providers and caregivers who care for these populations by offering additional resources and support to encourage care delivery transformation. This includes areas like identifying and addressing health-related social needs that often drive disparities in care quality and outcomes.

All of our strategic objectives directly inform the nine new model tests we've announced between 2022 and 2024 and have influenced the 37 active models and initiatives we have in place in 2024. Our new model tests were thoroughly and thoughtfully designed to address challenges that negatively impact the lives of Americans, such as high rates of maternal mortality, which disproportionately affect women of color, the need for caregiver support for patients with dementia, and broader issues aimed at strengthening the foundations of the U.S. health system, such as the need to enhance our primary care infrastructure.

In addition to our maternal health model, which will provide funding and technical assistance for up to 15 Medicaid agencies to improve access, reduce disparities, and improve outcomes for mothers and their newborns, other models we've announced include the Innovation in Behavioral Health Model. This model will improve the quality of care and outcomes for adults with behavioral health issues through partnerships with state Medicaid agencies. Another model, the Cell and Gene Therapy Access Model, aims to improve the lives of individuals on Medicaid by increasing access to novel and potentially transformative gene therapies. The initial focus will be on individuals with sickle cell disease, a genetic blood disorder that disproportionately affects Black Americans.

For models focused on strengthening our health care system's foundation, we have prioritized bolstering our primary care infrastructure. The Making Care Primary Model, announced in 2023, is a 10-year initiative aimed at improving primary care for people on Medicare and Medicaid by supporting better care management and coordination and addressing health-related social needs. This model is currently operating in eight states, selected based on several factors, including geographic diversity, equity opportunity, and current CMS Innovation Center footprint. A particularly exciting and ambitious model is the All-Payer Health Equity and Development (HEAD) Model, announced in 2024. This model provides funding to states to improve outcomes and reduce costs by strengthening primary care coordination. It aims to advance health equity by requiring participating states to develop a statewide and cross-sector governance structure and health equity plan that outlines community-driven strategies for improving population health and reducing disparities.

I believe these models have a high likelihood of making meaningful improvements in the health and lives of Medicare and Medicaid beneficiaries. I also want to take a moment to acknowledge the hard work of the CMS Innovation staff over the past years. Not only have they been involved in developing new model tests, but they've also been continuing to steward many other aspects of our portfolio. I've been privileged to work with such a talented and committed team. They do what they do because they are dedicated to improving the health system for patients and providers. Our portfolio touches many areas of health care, including care for individuals with cancer, kidney disease, and care during hospitalizations for conditions like hip and knee replacements. The accomplishments across our entire portfolio are too numerous to name, but I sincerely thank the staff for their dedication, ingenuity, and commitment to the work of the Innovation Center.

Finally, I'm also immensely proud of our various cross-cutting initiatives that are advancing how we think about the success and impact of our models. We've laid out a quality pathway to reimagine and expand how we evaluate success for our models. For so long, cost has been the primary focus when assessing the impact of health care initiatives. While cost is a key dimension and an important factor in high-value care, so too is quality. With the quality pathway, we are laying the groundwork to consider a model's impact on the quality of care, including outcomes that are reported directly by patients and their caregivers. This pathway will serve as a guide for future model expansion. Our transformation initiative, along with efforts to assess the spillover effects of our models, is also essential in helping us understand and describe the broader impacts of the Innovation Center models on the health system as a whole. While we are still in the early

stages of exploring research designs to systematically measure and track these spillover effects, I believe this work will be crucial to ensuring the sustainability and continued success of the Innovation Center's efforts moving forward. With that, I'll turn it over to Dr. Dora Hughes. Thank you.

Dr. Dora Hughes: Thank you, Liz. Good afternoon. I'm Dora Hughes, CMS' Chief Medical Officer and Director of the Center for Clinical Standards and Quality, or CCSQ. CCSQ, along with CMS, is committed to improving the safety, quality, equity, and coverage across the care continuum to promote optimal health for all. Today, I'll be sharing highlights of key initiatives and activities over the last four years that have helped advance these goals. About two years ago, with CCSQ at the lead, the CMS Innovation Center, the Center for Medicaid and CHIP Services, and the Center for Medicare came together to align efforts to advance quality, safety, and equity. These aligned efforts culminated in the development of the CMS National Quality Strategy, in which we outlined four focus areas and eight goals that we believe would allow CMS to be successful. These goals focus on outcomes, safety, resiliency, equity, and patient engagement, among others.

As one tangible outcome of this cross-center initiative, CMS announced a Universal Foundation of measures for adults and children—measures that CMS would use across our various programs, models, and initiatives whenever possible. The Universal Foundation will allow us to measure quality across our programs, clarify expectations and interests to our stakeholders, and reduce burden. It has been very well received. In the area of equity, we've made significant progress as well. Screening for social determinants of health (SDOH) is now required across all 21 of our statutory quality reporting and payment programs, affecting hospitals, home health, hospice, and more. We know that to improve outcomes, we need to assess the needs of beneficiaries holistically, including both clinical and social needs, if we are to be successful in moving the needle on quality outcomes.

As another highlight, I would mention our work in maternal health. Specifically, for CCSQ, we launched the Birthing Friendly Initiative two years ago to recognize hospitals engaged in maternal health quality collaboratives and those implementing initiatives to improve maternal care. We've expanded this effort with the first-ever Maternal Health Obstetrical Condition of Participation (COP), finalized as part of the calendar year 2024 Outpatient Prospective Payment System (PPS) rule. This Maternal COP clarifies the requirements and expectations for hospitals and critical access hospitals providing obstetric services, addressing staffing, training, quality assessment, performance improvement, and emergency response.

As two other clinical highlights, I would note that CCSQ and the CMS Innovation Center began working with the Health Resources and Services Administration (HRSA), co-leading the Organ Transplantation Affinity Group to tackle disparities in organ transplantation rates. We are also collaborating with HRSA and other federal agencies on behavioral health, drafting the first-ever CMS Behavioral Health Strategy, which serves as a guiding framework for our work here at CMS.

Next, I want to highlight CMS' Quality Improvement Organization (QIO) program. This program helps implement best practices to improve quality and safety. QIO networks work with

hospitals, clinicians, dialysis facilities, nursing homes, and community partners to provide expert quality improvement assistance, evidence-based interventions, and other resources. Our tribal QIO program supports the Indian Health Service and tribally operated facilities, in support of American Indian and Alaska Native communities. Our next five-year program, the 13 Scope of Work QIO Program, will continue to advance the agency's quality priorities.

Regarding CCSQ's coverage activities, we've started implementing the new Transitional Coverage for Emerging Technologies (TCET) pathway. This pathway will offer predictability and clarity for manufacturers seeking CMS coverage, facilitating access to innovative therapies for beneficiaries and insurance for providers. Additionally, we continue to expand access to preventive services through national coverage determinations, including HIV pre-exposure prophylaxis (PrEP) and expanded colorectal cancer screening.

As a final highlight, I would mention that CCSQ issued minimum staffing standards for long-term care facilities earlier this year. We know that the best predictor of quality care in nursing homes is staffing levels. Through this historic rule, we are ensuring that registered nurses, licensed practical nurses, licensed vocational nurses, and nurse aides are providing 24/7 care to some of our frailest and most vulnerable residents in long-term care facilities.

All of these accomplishments have taken place alongside CCSQ's ongoing work. We oversee and certify more than 30,000 facilities every year, including 14,000 nursing homes, 7,000 hospices, and 4,000 hospitals. Additionally, we oversee more than 300,000 clinical laboratories. CCSQ implements 21 statutory quality payment programs and oversees health and safety standards for 21 Medicare and Medicaid participating providers and suppliers. The sheer scale and scope of CCSQ's programs are tremendous, and they are matched by the commitment and dedication of the CCSQ staff who lead this critical work. It is truly amazing what we've been able to achieve. With that, I'm going to turn it over to Dara Corrigan, Director of the Center for Program Integrity. Dara, over to you.

Dara Corrigan: Thank you, Dora. Hello, everyone. I'm Dara Corrigan, the Director of the Center for Program Integrity (CPI). Our mission is to prevent, detect, and combat fraud, waste, and abuse in Medicare, Medicaid, and the Marketplace. We are continually working to protect federal dollars, prevent bad actors, and safeguard access to care. I'm happy to share some of our key accomplishments over the past few years.

First, I want to talk about our work safeguarding the Federally Facilitated Marketplace. Earlier this year, CMS reaffirmed its commitment to protecting consumers in the Marketplace by ensuring that they are enrolled in the plan of their choice and terminating brokers who did not obtain consent. CPI has taken significant steps to accelerate monitoring and oversight of agents and brokers. Since June 2024, we have suspended over 900 agents' and brokers' Marketplace agreements. Many of these individuals are now prohibited from participating in Marketplace enrollment for the next three years.

Secondly, I'd like to highlight our work preventing billions of dollars from reaching fraudulent companies. In early 2023, CMS identified a concerning rise in urinary catheter billings attributed to a small group of 15 suppliers. Through investigative efforts, we found that many people had

never received catheters, physicians did not order them, and the supplies were not reasonable or necessary. We were able to stop over 99% of the payments to these suppliers, preventing over $4.2 billion in improper payments.

Third, we implemented an innovative strategy to combat the unprecedented increase in hospice enrollments and exploitation of Medicare beneficiaries. We visited every hospice across the country and began reviewing claims prior to payment in four high-risk states—California, Nevada, Arizona, and Texas. Our efforts have led to a 65% decrease in new hospice enrollments, with no impact on the availability of critically needed hospice care.

Finally, I'd like to mention the financial impact of our work across the agency and with our law enforcement partners. Over the past few years, our activities have saved Medicare over $40 billion, producing an overall return on investment of about $8 for every $1 spent. We've achieved similar savings working with federal-state partners in Medicaid and CHIP. We're excited to build upon these accomplishments in 2025 with the help of the most dedicated staff I've ever worked with. Now, I'll turn it back over to Eden. Thank you very much.

Eden Tesfaye: Thank you, Dara. And thank you to all of our leaders at CMS who provided remarks about all the wonderful work we've done and have been able to accomplish throughout the years here. Now, with that, it's my pleasure to introduce CMS Administrator Chiquita Brooks-LaSure to close out our final CMS National Call Update. Administrator, over to you.

Chiquita Brooks-LaSure: Thank you so much, Eden, and a good afternoon—or good morning to those of you on the West Coast. As you all know, this will be my last stakeholder call as CMS Administrator for the Biden-Harris Administration. It has been, and remains, the greatest honor and privilege to serve in this role. I am incredibly proud of what we've accomplished together, and I want to take a moment to express my sincere gratitude for your partnership, your advocacy, and the invaluable roles that each of you has played in our efforts to improve our health care system. In just a few short years, we've achieved so much, working side by side to advance our collective mission. In case you missed it, we recently shared our accomplishments over the last four years across our strategic pillars: advancing equity, expanding access, engaging with partners, driving innovation, protecting our programs, and fostering excellence. When I read through the progress we've made across the three Ms—Medicare, Medicaid and CHIP, and the Marketplaces—I was truly blown away by all the work we've done to improve the overall American health care system. As you've heard from all the leaders here at CMS today, there has been a tremendous amount of work accomplished.

We always describe our accomplishments in broad strokes. Our work together impacts over 160 million people, and it's a vast responsibility. But it is thanks to you that we are able to reach the people in our communities—no matter what they look like, where they live, or how much money they have. It is because of your efforts that we see the impact of our work in our own neighborhoods and own families. For example, the person who cuts your hair or the person who makes your coffee on your way to work—they might not have been able to afford health care coverage a few years ago, but thanks to our collective work, they now have access to affordable care. Thanks to your dedication, we have seen record-high enrollment across the three Ms—Medicare, Medicaid, and the Marketplaces. And while I have no favorites, employer coverage

has also seen significant strides. This is a huge achievement of which we should all be proud. It is our mission to strengthen the care that people in our programs receive—the care that our neighbors and our families rely on.

Among my proudest achievements is the work we've done to strengthen health care for women—for our daughters, mothers, aunts, and best friends. We took decisive action after the Supreme Court overturned Roe v. Wade, reaffirming that all people have the right to stabilizing care when they go to a Medicare-covered hospital's emergency room during a medical emergency. We communicated to hospitals that EMTALA (Emergency Medical Treatment and Labor Act) protects this right, including when abortion care is the necessary stabilizing treatment. We also addressed the maternity care crisis in our country, which, as we all know, disproportionately affects Black women, American Indian, Alaska Native, and Native Hawaiian Pacific Islander women—regardless of income and education. To help combat this, we created the Birthing Friendly Hospital Designation, which is now featured on Medicare's Care Compare website as well as many health care plan provider directories.

We partnered with states to extend Medicaid and CHIP coverage for 12 months postpartum (up from just two months) to ensure new moms have the critical coverage they need. This coverage is now available in 46 states, D.C., and the Virgin Islands. Medicaid and CHIP have been a lifeline for the 80 million people who depend on them for access to health care and community supports. The best way to describe the work we've done in Medicaid over the last few years is to treat it like any other M—whether you are in the commercial market, enrolled in Medicaid or CHIP, or in Medicare. Everyone deserves access to the care they need, to see their doctors, primary care physicians, and other clinicians. That is the work that we have done and tried to do over the last couple of years.

I could go on and on, and I hope you appreciate the work we've done across the spectrum, in the way we've tried to make our models more accessible to the safety net and rural states, ensuring their work is reflected. I'm particularly proud of our GUIDE (Guiding an Improved Dementia Experience) Model, which aims to treat people with dementia and support their caregivers—recognizing the immense value of that work. Of course, we can't end without acknowledging the incredible life-changing effect of our Medicare prescription drug benefit. This has made prescription drug coverage more affordable for millions of people. We're excited about the $2,000 cap coming next year and the ongoing benefits that will come from negotiating lower prescription drug costs.

Again, we could go on and on about all the work that's been accomplished, but we couldn't have done it without the support of the people on this call—your essential role in making sure that people across this country receive the care they need. We know we can count on your dedication and leadership to continue this important work, even after some of us are no longer here. Thank you. And now, back to you, Eden.

Eden Tesfaye: Thank you, Administrator, and thank you to everyone who joined us today and for all of your time, efforts, and partnership throughout the last three and a half, four years. With that, we hope you have a great rest of your day. Bye.