The Centers for Medicare & Medicaid Services:

A Year in Review
June 2021 - May 2022

Over the last year, the Centers for Medicare & Medicaid Services (CMS) outlined a strategic vision for CMS that delivers meaningful, person-centered, and equitable care to the people we serve.

Over the last year, enrollment in Medicare, Medicaid and the Children's Health Insurance Program (CHIP), and the Marketplace topped 150 million people — an all-time high. The pandemic also heightened the need for CMS vigilance around the safety, quality, and equity of the nation's health care system. To meet this moment, CMS outlined an ambitious strategic plan and produced policy that advances health equity, expands access to health coverage, drives innovation while the agency engages partners and people with lived experience, protects its programs for future generations, and fosters excellence amongst CMS staff.

2021-2022 Year Accomplishments

Advancing Health Equity

In April 2022, **CMS announced the CMS Health Equity Action Plan,** which lays out the central role advancing health equity plays in the work of all CMS centers and offices. This work includes working with and sharing best practices across states, health care facilities, providers, insurance companies, pharmaceutical companies, people with lived experience, researchers, and other key stakeholders to drive commitments to advance health equity.

KEY IMPACT NUMBERS

- CMS **increased enrollment** in HealthCare.gov states among **Hispanic people by 26% and Black people by 35%.**
- CMS **expanded language access** by **translating the Medicare & You handbook into three additional languages** and **advertising for HealthCare.gov in five new languages —** Chinese (Mandarin and Cantonese), Korean, Vietnamese, Tagalog, and Hindi.
- CMS **expanded** and standardized the collection and use of **data, including on race, ethnicity, preferred language, sexual orientation, gender identity, disability, income, geography,** and other factors across CMS programs.

- CMS **incorporated screening for — and promoted broader access to — health-related social needs,** including greater adoption of related quality measures, coordination with community-based organizations, and collection of social needs data in standardized formats across CMS programs and activities. For example, CMS issued proposed policies to encourage hospitals to build health equity into their core functions in the fiscal year 2023 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) proposed rule.

KEY ACCOMPLISHMENTS

- CMS released the CMS Framework for Health Equity to address health disparities as a foundational element across all our work — in every program and across every community. Using five priority areas, CMS will use this **framework to design, implement, and operationalize policies and programs to support health for all people** served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.
- **CMS has begun approving states' postpartum coverage expansions, from 60 days to 12 months, made possible by the American Rescue Plan (ARP).** California, Florida, Kentucky, and Oregon have joined South Carolina, Tennessee, Michigan, Louisiana, Virginia, New Jersey, and Illinois in extending Medicaid and CHIP coverage from 60 days to 12 months postpartum. CMS continues working with other state partners to extend coverage for 12 months after pregnancy, including Indiana, Maine, Minnesota, New Mexico, Pennsylvania, West Virginia, North Carolina, Washington, and Connecticut, as well as the District of Columbia.
- CMS supports states in investing in home- and community-based services (HCBS). Under Section 9817 of the ARP, states have submitted to Center for Medicaid and CHIP Services (CMCS) spending plans totaling **$25 billion across states to enhance, expand, and strengthen HCBS under Medicaid**. In May 2021, CMCS issued guidance on how states can receive the enhanced HCBS funding.
- CMCS released a fact sheet on **Health Coverage Options for Afghan Evacuees** last fall to support Afghan evacuees arriving in the United States. With CMCS guidance and congressional support, most Afghan evacuees are able to access health coverage through Medicaid and CHIP programs.
- **CMS quadrupled the number of Marketplace Navigators** available to make it easier for families and underserved communities to access health coverage options through HealthCare.gov.
- The Center for Medicare (CM) issued a finalized rule that accelerates the shift from paying for home health services based on volume to a system that incentivizes value and quality.
- All proposed payment rules are seeking feedback on ways to attain health equity for all patients through policy solutions. This includes enhancing reports on Medicare/Medicaid dual-eligible, disability status, people who are LGBTQI+, religious minorities, people who live in rural areas, and people otherwise adversely affected by persistent poverty or inequality.
- CMS is considering stratification of **measures to address inequities** across CMS hospital quality reporting programs as part of our fiscal year 2023 IPPS and LTCH PPS proposed rule.
- CMS proposed and finalized steps to **close health equity gaps** by focusing on improving the experience of people with Medicare who are battling **End-Stage Renal**

Disease (ESRD). The calendar year 2022 ESRD Prospective Payment System (PPS) rule updated ESRD PPS payment rates, made changes to the ESRD Quality Incentive Program, and revised the ESRD Treatment Choices (ETC) Model. The ETC Model policies aim to encourage dialysis providers to decrease disparities in rates of home dialysis and kidney transplants among ESRD patients with low socioeconomic status. This model is the agency's first Center for Medicare and Medicaid Innovation (CMMI) model to address health equity directly.

- CMS introduced Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model. **ACO REACH will test an innovative payment approach to better support care delivery and coordination for patients in underserved communities** and will require that all model participants develop and implement a robust health equity plan to identify underserved communities and implement initiatives to measurably reduce health disparities within their beneficiary populations.
- The Center for Consumer Information and Insurance Oversight (CCIIO)also increased the Essential Community Provider threshold to provide greater access to various providers for low-income or medically underserved consumers.
- CMS **released the Behavioral Health Strategy**, covering multiple elements, including access to prevention and treatment services for substance use disorders, mental health services, crisis intervention, and pain care. The strategy further enables care that is well-coordinated and effectively integrated.
- CMS finalized rules that make **telehealth for behavioral health services permanent in Medicare**, which allows for greater access and equitable services for those who may not otherwise connect to mental health service providers.
- In the calendar year 2022 Physician Fee Schedule (PFS) final rule, the agency encouraged growth in the Medicare Diabetes Prevention Program Expanded Model.
- In the calendar year 2022 Physician Fee Schedule (PFS) final rule, the agency **boosted payment rates for vaccine administration**.
- CMS included several key proposed initiatives and sought comments through the fiscal year 2023 IPPS and LTCH PPS proposed rule, including:
    - CMS proposed **three new social determinants of health quality measures** for hospitals and is seeking comment on a cross-setting framework to advance health equity by identifying and addressing disparities.
    - CMS proposed **adding a "Birthing-Friendly" hospital designation** to Care Compare and is also seeking feedback on ways that CMS can advance equity and reduce disparities in maternal care.
    - Finally, CMS is soliciting comments on opportunities to **address climate change** across care settings.
- CMS approved a **California** request for a five-year extension of its 1115 demonstration and managed care section 1915(b) waiver. The combination, known as "CalAIM," creates important **new pathways that provide important provisions in managed care to advance health equity, fund key services**, like medically tailored meals, and improve access to care.
- CMS implemented a new feature on **Medicare.gov** that allows people to view and **compare nursing home COVID-19 vaccination rates**. The new tool empowers residents, their families, and caregivers with data to help make informed decisions.
- CMS sought comment on a potential **health equity index measure** for **Medicare Advantage (MA) Star Ratings** that would take into account how well plans advance

health equity, including screening for health-related social needs, such as food insecurity, housing insecurity, and transportation problems.

- CMS supported language access by requiring a **multi-language insert in all required communications by MA plans** that directs beneficiaries to further free language and translation assistance.
- **For 11 million individuals dually enrolled** in Medicare and Medicaid, CMS has worked to close health disparities by **delivering person-centered integrated care** that can lead to better health outcomes for enrollees and improve the operational functions of these programs. Closing health disparities requires all MA special needs plans to **annually assess certain social risk factors for their enrollees** because identifying social needs is a key step to delivering person-centered care.
- CMS has taken steps to **include race and ethnicity as optional questions as part of MA enrollment.** CMS continues to explore the collection of additional demographic information in Traditional Medicare. With these data, Medicare can work both internally and with external researchers to identify care gaps to inform future policy development.
- CMS funded **more medical residency positions** in hospitals serving rural and underserved communities — one of the largest increases in partially Medicare-funded residency slots in a decade. **CMS is funding 200 new Medicare-funded slots per year over five years**. Having providers train in the very communities that need them most means that these providers will be better equipped to treat these disadvantaged communities.

Expanding Access

KEY IMPACT NUMBERS

- The **Marketplace has more people enrolled in health coverage** than ever before, with more than 14.5 million people enrolled. That's a **record-high — 21% more than last year.**
- **The uninsured rate in 2021 fell** after the Biden-Harris Administration enacted the ARP, opened a Special Enrollment Period (SEP), and expanded outreach efforts to historically uninsured communities. **The uninsured rate for the U.S. population was 8.9% for the third quarter of 2021 (July - September 2021), down from 10.3% for the last quarter of 2020.**
- **Expanded Medicaid in Oklahoma and Missouri in 2021.** Since Oklahoma expanded on June 1, 2021, the state has enrolled 291,219 individuals. Since Missouri expanded on October 4, 2021, the state has enrolled 175,668 individuals.
- As a result of the **ARP**, **CMCS launched a new "one-stop-shop" on Medicaid.gov** to make accessible states' HCBS spending plans under ARP Section 9817.
- As a result of the **ARP, CMCS awarded $15 million in grants to 20 states to help support community-based mobile crisis intervention services** — essential tools to rapidly provide critical services to people experiencing mental health or substance use crises by connecting them to a behavioral health specialist 24 hours per day, 365 days a year. CMCS also offers state Medicaid agencies a new option to expand community-based mobile crisis intervention services.
- CMCS committed a **record $49.4 million to fund organizations that can connect more eligible children, parents, and pregnant individuals to health care coverage through Medicaid and CHIP**. Awardees — including state/local governments, tribal

organizations, federal health safety net organizations, non-profits, schools, and others - received up to $1.5 million each for three years to reduce the number of uninsured children by advancing Medicaid and CHIP enrollment and retention.

- In FY 2021, CMS **enrolled over 239,000 new providers in the Medicare program,** providing additional access to care for 64.2 million people with Medicare during the pandemic. Of the new providers, over 102,000 providers enrolled in the top 10 states with the highest rates of COVID cases
- As a result of CMS efforts, enrollment grew in the **Medicare Savings Programs: 10.3 million people are enrolled in these programs as of December 2021**, a more than 800,000 increase from December 2020.
- CMS has issued a final rule that **put an end to Pharmacy Benefit Manager's retroactive application of direct and indirect remuneration (DIR) fees under Medicare Part D, requiring that they be reflected in the negotiated price the patient pays at the pharmacy counter**. The rule included all price concessions be passed along at the point of sale beginning on January 1, 2024.

KEY ACCOMPLISHMENTS

- **The Center for Medicare (CM)**
  - People enrolled in Traditional Medicare and MA are now able to get **eight over-the-counter COVID-19 tests per month covered at no cost to them.** This is the first time that Medicare has paid for an over-the-counter service or test.
  - CMS is **paying for people with Medicare to receive a second COVID-19 booster** shot of either the Pfizer-BioNTech or Moderna COVID-19 vaccines without cost-sharing as it continues to provide coverage for this critical protection from the virus. People with Medicare pay nothing to receive a COVID-19 vaccine and there is no applicable copayment, coinsurance or deductible. People with Medicaid coverage can also get COVID-19 vaccines, including boosters, at no cost.
  - CMS is proposing to make it easier for people to enroll in Medicare and eliminate delays in coverage **by reducing the waiting period for Medicare coverage after enrollment, creating Medicare SEPs,** and allowing eligible people to receive Medicare Part B coverage without a late enrollment penalty.
  - CMS finalized a rule that set timeframes and standards/thresholds to **ensure MA plans support access to needed services during emergencies and disasters,** like the COVID Public Health Emergency (PHE), and limit disruption in access to health care in the MA plan's service area.
  - Following congressional action, CMS is creating a **new Part B immunosuppressive drug program (Part B-ID)** for individuals who lose Medicare based on ESRD status 36 months after a successful kidney transplant and who do not have certain other health coverage.
  - **Medicare Part D beneficiaries will see reduced out-of-pocket costs** for prescription drugs starting in 2024, resulting from a new requirement that Part D plans pass along the price concessions received from pharmacies at the point of sale.
  - CMS now requires that **MA plans demonstrate they have a sufficient network of contracted providers** to care for beneficiaries before CMS approves an

application for a new or expanded MA contract. Requiring applicants to demonstrate compliance with network adequacy standards as part of the application process will **strengthen CMS'S oversight of an organization's ability to provide an adequate network of providers to deliver care to MA enrollees.**

- CMS finalized a rule to gradually **reduce cost-sharing for procedures that a beneficiary needs as a result of a colon cancer screening** (for which there is no cost-sharing). If a practitioner has to remove a polyp at the same time as the screening, CMS is reducing the amount of cost-sharing the beneficiary will pay for the polyp removal over time. The cost-sharing will be zero by 2030.

- **The Center for Medicaid & Children's Health Insurance Program Services (CHIP)**
  - As part of the Biden-Harris Administration's work to advance health equity and reduce health disparities, **CMS sought feedback on topics related to health care access,** such as enrolling in and maintaining coverage, accessing health care services and supports, and ensuring adequate provider payment rates to encourage provider availability and quality. This Request for Information (RFI) is one of many actions CMS is taking to develop a more comprehensive access strategy in its Medicaid and CHIP programs. Feedback obtained from the RFI will aid in CMS'S understanding of enrollees' barriers to enrolling in and maintaining coverage and accessing needed health care services and support through Medicaid and CHIP.
  - Total enrollment for **Medicaid expansion**, Marketplace coverage, and the Basic Health Program in participating states has reached an **all-time high of more than 35 million people** as of early 2022.
  - Flexibilities provided by CMS during the COVID-19 public health emergency lead **enrollment in Medicaid and CHIP to grow by more than 16 million**, reaching record high levels of **nearly 87 million** as of January 2022.
  - CMS **committed a record $49.4 million to fund organizations that can connect more eligible children, parents, and pregnant individuals to health care coverage through Medicaid** and the Children's Health Insurance Program (CHIP). Awardees — including state/local governments, tribal organizations, federal health safety net organizations, non-profits, schools, and others — will receive up to $1.5 million each for a three-year period to reduce the number of uninsured children by advancing Medicaid/CHIP enrollment and retention.
  - CMS has provided states **an additional year to use funding** made available by the **American Rescue Plan (ARP) to enhance, expand, and strengthen home- and community-based services** (HCBS) for people with Medicaid who need long-term services and supports.
  - CMS announced that it would offer more than **$110 million to expand access to HCBS through Medicaid's Money Follows the Person** (MFP) program. First authorized in 2005, MFP has provided states with $4.06 billion to support people who choose to transition out of institutions and back into their homes and communities. The new Notice of Funding Opportunity (NOFO) makes individual awards of up to $5 million available for more than 20 states and territories not currently participating in MFP. These funds will support initial planning and implementation to get the state/territory programs off the ground, which would ensure more people with Medicaid can receive high-quality, cost-effective, person-centered services in a setting they choose.

- California, Florida, Kentucky, Oregon, South Carolina, Tennessee, Michigan, Louisiana, Virginia, New Jersey, and Illinois have extended Medicaid and CHIP coverage from 60 days to 12 months postpartum. CMS continues working with other state partners to extend coverage for 12 months after pregnancy, including Indiana, Maine, Minnesota, New Mexico, Pennsylvania, West Virginia, North Carolina, Washington, and Connecticut, as well as the District of Columbia. As a result of these efforts, **as many as 720,000 pregnant and postpartum individuals across the United States, annually, could be guaranteed Medicaid and CHIP coverage for 12 months after pregnancy.**
- **CMS awarded $15 million in planning grants to 20 states to support expanding community-based mobile crisis intervention services** for Medicaid beneficiaries. By connecting people who are experiencing a mental health or substance use disorder crisis to a behavioral health specialist or critical treatment, these services—which will be provided by funding from the American Rescue Plan (ARP)— and will be available 24 hours per day, every day of the year, can help save lives.
- CMS is working with states to **promote access to Medicaid services for people with mental health and substance use disorder (SUD) crises**. Authorized under President Biden's American Rescue Plan (ARP), states have a new option for supporting community-based mobile crisis intervention services for individuals with Medicaid. This new option will help states integrate these services into their Medicaid programs, a critical component in establishing a sustainable and public health-focused support network.

- **The Center for Consumer Information and Insurance Oversight (CCIIO)**
  - CMS finalized a rule **making it easier for millions of consumers to find comprehensive, affordable health coverage** in 2023, including offering easy to compare standardized plans through the federal Marketplace.
  - Collectively, these proposals build on the Biden-Harris Administration's priority to build on the Affordable Care Act, lower health care costs, and make coverage options more equitable. President Biden's ARP has lowered health care costs for people**. The average monthly premium after tax credits would have been $59 per month higher, or 53 %, had the ARP not been in effect**. for plans purchased through the state or federal Marketplace.
  - **As a result of the ARP, an additional 400,000 people received tax credits that enabled them to enroll in health insurance coverage in 2022.**

Engaging Partners

KEY IMPACT NUMBERS

- CMS leadership held over **250 stakeholder public events,** including roundtables, listening sessions, keynote speeches, and fireside chats speaking engagements.
- CMS issued approximately **50 Requests for Information (RFIs).**

KEY ACCOMPLISHMENTS

- As part of preparing for once the PHE ends, **CMS convened** state Medicaid agencies, State-based Marketplaces, Medicaid Managed Care Organizations, Marketplace Qualified Health Plans, insurance commissioners, enrollment assistors, providers in both

rural and urban areas, plans and advocacy organizations to **discuss ideas and identify ways to ensure individuals are aware of their options and end up with the right health care coverage.**

- **CMS provided hundreds of briefings** to local stakeholders, including providers, partners, and congressional offices, on CMS'S proposed and final rules, innovation opportunities, and strategic priorities. CMS has worked through assisters and trusted community partners to reach those who benefit from our programs or are eligible to apply. At the same time, **CMS has facilitated hundreds of listening sessions** to gather stakeholder feedback on the agency's key priorities.
- **CMS convened quarterly national stakeholder calls** with representative leadership from each of the CMS centers and offices and engaged with thousands of stakeholders.
- **CMS issued approximately 50 RFIs** to garner stakeholder feedback on issues such as the implementation of the Rural Emergency Hospital program, long-term care staffing requirements, and the development of a comprehensive access strategy for people enrolled in Medicaid and CHIP.

Driving Innovation

By **increasing value-based arrangements through ACO participation and accelerating care transformation**, Medicare can continue to lead the way for payers, health care providers, and purchasers across the country to advance accountable care. Through:

  - **Alignment:** From the provider's perspective, multi-payer alignment is critical, and even aligning across CMS can help set the stage for broader alignment in our health care system.
  - **Equity**: For too long profound inequities have existed across our health care system, and the design of value-based arrangements can be a key way to advance equity. CMMI has undertaken an initiative to weave equity into every phase of model development, implementation, and evaluation to ensure that value-based care drives higher quality, including greater equity.
  - **Growth**: Established goal to have all people with Traditional Medicare as part of an accountable care relationship by 2030. Growth of accountable care relationships can improve quality, increase savings for Medicare, and promote innovative delivery of services that meet patients' needs.
- CMS is also working with states on innovative new ways to **expand and strengthen Medicaid and CHIP coverage.**
  - CMS approved an innovative new demonstration project in California, leveraging Medicaid as a tool to help address many of the complex challenges facing underserved communities. The demonstration takes a person-centered approach to meet the physical, behavioral, development, long-term care, oral health, and health-related social needs of all people with Medicaid in the state.
- CMS posted **new staffing measures on the Nursing Home Care Compare** website to provide consumers with information related to weekend staffing levels and staff turnover in nursing homes, including the level of total nurse and registered nurse staffing on weekends provided by each nursing home quarterly; the percent of nursing staff and number of administrators that stopped working at the nursing home over 12 months; and raw data so stakeholders can conduct their own analyses.
- **In response to the changing pandemic, CMS rapidly deployed guidance to increase access to FDA-approved at-home over-the-counter COVID-19 tests** for **people in Marketplace plans.**

KEY IMPACT NUMBERS

More than **110,000 providers participate in CMMI's Traditional Medicare models**, and more than 4.7 million people with Traditional Medicare receive care from providers in these models. Additionally, more than **865,000 people with Medicaid receive care from a provider, plan, or organization participating in a CMMI model**. The Medicare Shared Savings Program approved new ACOs, which increased the number of people with Medicare that receive care from a provider in an **ACO to over 11 million and the percentage of ACOs under two-sided risk to 59%, the highest number of risk-based ACOs since the program inception.**

KEY ACCOMPLISHMENTS

- **CMMI released a strategy refresh** that drives the delivery system toward meaningful transformation, paying for health care based on value to the patient instead of the volume of services provided, and delivering person-centered care that meets people where they are.
- CMS **finalized the nationwide expansion of the Home Health Value-Based Purchasing Model,** which improves the quality and delivery of home health care services to people with Medicare.
- **Two new CMMI models began their performance periods** (Kidney Care Choices (KCC) and Integrated Care for Kids models).
- **Two models launched additional cohorts**, including the Primary Care First and the Global and Professional Direct Contracting (GPDC) models.
- CMS announced that the GPDC would be redesigned as **ACO REACH.**
- **Two Traditional Medicare models began pre-implementation** (Expanded Home Health Value-Based Purchasing Model and Community Health Access and Rural Transformation Model);
- **Four new Request for Applications were released to participate in CMMI models**. These include the ACO REACH model, a second cohort of the KCC model, the MA Value-Based Insurance Design (VBID) and Hospice Component, and the Part D Senior Savings Model.
- CMS **engaged beneficiaries, providers, and other stakeholders in five CMMI public listening sessions** on the following topics: health equity, beneficiary engagement, safety net providers, advanced primary care, and the CMMI strategy.
- CMS **finalized policies to transition ACOs in the Medicare Shared Savings Program to all-payer quality measures** to increase the quality standard for Medicare's largest value-based payment program and promote health equity and interoperable health care networks.
- The ESRD Treatment Choices (ETC) Model. The ETC Model policies aim to encourage dialysis providers to decrease disparities in rates of home dialysis and kidney transplants among ESRD patients with low socioeconomic status. This model is the agency's first CMMI model to address health equity directly.
- The Center for Clinical Standards and Quality (CCSQ) is holding listening sessions and gathering feedback as it develops new coverage and payment strategies for emerging and cutting-edge therapies and technologies. We are ensuring CMS can be nimble in its approach to these new and exciting developments toward better treatments for patients.

Protecting Programs

KEY IMPACT NUMBERS

- CMS participated in several **fraud takedowns** with our law enforcement partners. These takedowns targeted fraud schemes exploiting the COVID-19 pandemic, telemedicine, substance abuse treatment facilities, opioid distribution, and other health care fraud.
    - ***COVID-19 Pandemic Exploitation.*** In May 2021, the Department of Justice (DOJ) charged 14 defendants for their alleged participation in **health care fraud schemes that exploited the COVID-19 pandemic and resulted in over $143 million in false billings**. In April 2022, DOJ charged **an additional 21 defendants**. These cases allegedly resulted in over **$149 million in COVID-19-related false billings to federal programs.** Between these two takedowns, the Center for Program Integrity (CPI) took adverse administrative actions against over 78 medical providers for their involvement in health care fraud schemes relating to COVID-19 or abuse of CMS programs.
    - ***Fraud schemes relating to Telemedicine, COVID-19 Health Care Fraud, Sober Homes, and Illegal Opioid Distribution.*** In September 2021, **DOJ charged 138 defendants, including 42 doctors, nurses, and other licensed medical professionals**, for their alleged participation in various health care fraud schemes that resulted in approximately $1.4 billion in alleged losses. The charges targeted fraud committed using telemedicine, COVID-19 health care fraud, substance abuse treatment facilities, or "sober homes," and other health care fraud and illegal opioid distribution schemes. CPI took action against 28 providers on behalf of people with Medicare coverage and to protect the Medicare Trust Fund.
    - In May 2022, DOJ charged 14 defendants for their alleged involvement in crimes related to the unlawful distribution of opioids. Twelve of the defendants were medical professionals. CPI took administrative action against six of the charged providers.

KEY ACCOMPLISHMENTS

- CMS is working on **setting minimum staffing requirements**, enhancing oversight and accountability, and making nursing home facility ownership more transparent so that potential residents and their loved ones can make informed decisions about care.
- For the first time, CMS **released data that show the quarterly hospital and nursing home mergers, acquisitions, and changes in ownership** since 2016 in response to the President's Executive Order on promoting competition. CMS is continuing to release updates on a quarterly basis, increasing transparency and allowing the public and researchers to analyze and understand trends.
- CPI **expanded the Open Payments program** to add additional providers. This national transparency effort allows information to be made public about the payments physicians and teaching hospitals receive from drug and medical device companies.
- CPI released a Federal Register Notice to address some risks that occurred during the PHE related to orthoses and certain durable medical equipment.
- CPI maintained its **collaborative efforts with law enforcement** to **eliminate fraud, waste, and abuse throughout the PHE.**

- CCSQ led the development of a historic regulation to **require COVID-19 vaccination of health care workers at facilities participating in the Medicare and Medicaid programs** to ensure patient safety and provide stability and uniformity across the nation's health care system. CMS continues to leverage our Quality Improvement Organizations to assist with education and technical assistance to nursing homes regarding vaccines and infection control.
- CM continues to actively **enforce the hospital price transparency** requirements to ensure people know what a hospital charges for items and services. CMS continues to monitor hospitals' compliance with the requirements by evaluating complaints made by individuals or entities to CMS, reviewing individuals' or entities' analysis of noncompliance, and auditing hospitals' websites. Based on our initial months of experience with enforcing the hospital price transparency requirements, we finalized an increased civil monetary penalty under the Medicare Hospital Outpatient PPS final rule. As of June 2022, CMS has issued approximately 352 warning notices to hospitals that have been determined by comprehensive review to be out of compliance with the hospital price transparency regulations. CMS also issued 157 corrective action plan requests to hospitals that previously received warning notices, but have not yet corrected deficiencies, and 171 hospitals received case closure notices after having addressed previous citations.
- Across its rules that rely on input from facilities to set payment rates, CMS made proposals to **increase payment stability by smoothing out significant year-to-year changes in wage indices.** For the first time in 20 years, CMS updated clinical labor wages that are used to calculate practice expenses under the PFS. As a result, payments to primary care specialists that involve more clinical labor, such as family practice and internal medicine specialties, are expected to increase. This increase will drive greater person-centered care for these services particularly for disadvantaged groups and underserved communities. It will also advance accurate payments and ongoing stewardship of the Medicare program, consistent with ongoing efforts to update supplies/equipment in practice expense.
- CMS finalized a rule to promote value by reinstating detailed medical loss ratio reporting requirements (in effect for CYs 2014-2017) for MA plans. **CMS is also increasing transparency by requiring new reporting on spending on MA supplemental benefits** not available under Traditional Medicare (e.g., dental, vision, hearing, transportation).
- CMS is **protecting people from surprise medical billing** by implementing the No Surprises Act, which went into effect on January 1, 2022, and working to ensure people know their new rights under the law Including getting emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers. Through new rules aimed to protect consumers, excessive out-of-pocket costs are restricted, and emergency services must continue to be covered without any prior authorization, and regardless of whether or not a provider or facility is in-network.
- **CMS announced its National Quality Strategy,** a cross-cutting initiative that is raising the bar for a high-value health care system that promotes quality outcomes, safety, equity, and accessibility for all individuals, especially those in underserved and under-resourced communities. The strategy focuses on a person-centered approach to quality and safety and seeks to improve an individual's overall care journey.

Fostering Excellence

KEY IMPACT NUMBERS

- CMS implemented the diversity, equity, and inclusion **(DEI) Basics Course — 85% of all CMS managers have taken this course.**
- Launched the **DEI Ambassadors Program**, in which 85 CMS employees will work in tandem within CMS and with DEI stakeholders to communicate ongoing DEI commitments and initiatives.
- CMS developed a strategic plan framework to improve access, equity, affordability, and quality of health care coverage for CMS beneficiaries. There are **55 projects across the agency that will improve employee engagement and increase diversity, equity, and inclusion.**

KEY ACCOMPLISHMENTS

- **CMS launched a DEI Strategic Plan** for the first time. CMS established a DEI Council to guide and support the implementation of the strategic plan and the ongoing integration of DEI into all aspects of work at CMS.
- CMS developed a strategic plan framework to improve access, equity, affordability, and quality of health care coverage for CMS beneficiaries. This work builds upon the vision embedded in the six strategic pillars of the agency.
- In addition, **for the first time, CMS outlined a set of 13 cross-cutting initiatives that will draw upon critical work done across the agency to drive results.** Together with the HHS Strategic Plan, the Evidence Act, and other key inputs, this framework will steer the agency leadership in making data-driven policy, program, and operational decisions.
- CMS continues to intentionally **foster integration** across agency components, including all CMS locations, to better leverage programmatic expertise in addressing multidimensional issues and promoting alignment and consistency across programs.
- CMS continues to **value and support its workforce**, including bolstering the agency's technology infrastructure to better enable remote and hybrid collaboration; providing high-quality onboarding and manager training programs; and supporting robust Employee Resource Groups, recognized by CMS's score in the top quartile of all federal agencies in employee satisfaction.