CMS Vision for the Future of Medicare

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00:43 - NATALIE DAVIS
Hello, everyone and thank you for coming today. I'm Natalie Davis, the CEO of United States of Care. We are thrilled to welcome such a large virtual group today as we talk with Dr. Meena Seshamani, the Deputy Administrator for the Center for Medicare and Medicaid Services commonly known as CMS, and the director for the Center for Medicare. She's here to talk to us about CMS's vision for the future of Medicare. Before we jump in, let me share a little bit of background on United States of Care. We are nonpartisan nonprofit, commited to ensure that everyone has access to quality affordable health care. We do our work in a lot of unique ways, but it always starts with understanding people's true needs for the health care system. We take what we hear from people across the country and champion fair and common sense changes to meet people's urgent needs. And in a system that often feels unfair or too profit driven, our goal is simple to ensure that every person can access health care regardless of who they are, how much money they make, or where they live. And our research finds that this goal is nearly universally supported with 92% of people believing everyone deserves to have access to quality, affordable health care. As we talk to people across the country, it's clear there's agreement on four goals that people have for our health care system: the certainty they can afford their health care, the security and freedom that dependable coverage provides as life changes, people can get personalized care they need when and how they need it, and for people experience a health care system that's understandable and easy to navigate. These four goals are backed up by a dozen smart and targeted solutions to meet people's urgent needs. Together, these are called United Solutions for Care. And you can find them on our website. They're our North Star, and they're how we work with partners across the country. There's so many ways we work with partners, building new policies, delivering and paying for care differently, legislative advocacy and regulatory work, which is why we're so excited to talk to Meena today. Her and her colleagues are leading such important work both within CMS across the agency, and within the Department of Health and Human Services. Medicare's approach to care delivery and payment changes have no doubt ripple effects throughout our entire health care system and touch every one of us and all the work that we do. And we know it is of course a major force for health equity. And so we're excited to have this conversation today. Meena, I really would love to hand it over to you for you to talk through the vision that CMS has laid out for the future of Medicare. And then we can talk through a number of questions. And we have the Q&A function available

for all of you watching to make sure that you can ask the questions you have for Meena and for CMS as well. So Meena, excited to hand it over to you.

03:36 - MEENA SESHAMANI
Well, thank you so much for having me. It's wonderful to be here with all of you. And I have to thank all the work that you and everybody who's joining us are doing because I think as we know, we have the healthcare ecosystem that involves so many pieces to the puzzle in terms of the people who we serve, and who want to, you know, get the kind of care that they want and all of the various people who try to serve them from communities to health care providers and plans and employers. And so really a huge thank you to bringing together that coalition to discuss these things. That's the only way that we're going to be able to make progress in our system. And you know, Natalie, as you mentioned, Medicare is quite large and can have quite an enormous impact. Right? We serve 63 million people, those aged 65 and older, people with disabilities, people with end stage renal disease. We partner with more than a million clinicians, more than 6000 hospitals. And we pay one in $5 in the healthcare system, you know, almost a trillion dollars in claims each year. And so when you make a change in Medicare, it really can have ripple effects on the entire ecosystem. And that is an opportunity and a responsibility that I take very seriously, as we're thinking about what we want to do. You know, so when I came into this role, you know, thinking about what is it what have we learned from the pandemic, and even outside the pandemic of where we want the future of caring for this population to be. And it really centers around several pillars. And, you know, we published a vision for Medicare, I published with our administrator Chiquita Brooks-LaSure and Liz Fowler, our Innovation Center Director back in January, with some subsequent pieces, you know, after that is more deep dives. But at a high level, we want to make sure that we are leveraging Medicare to advance health equity, that we are driving innovation so that we can have high quality, whole person care, and that we are promoting affordability and sustainability for the program. And underlying all of that is how we engage with again, all parts of that ecosystem, I want to make sure that we are hearing from voices that you don't always hear from that we are engaging everyone who is involved. Because again, I think that's how you can really drive systemic change. And I think as we get into this conversation, we can kind of dive a little bit more into each of these pillars and kind of how some of this work is coming to light already through some of the work that we have been doing and where that lays the groundwork for work to come.

06:26 - NATALIE DAVIS
Great. So I'd love to start by asking you about your role as a practicing physician. How is your experience as a physician really shaped the work that you're doing at Medicare? Are there patients stories that come to mind for you that really have shaped your career? Tell us tell us about Dr. Seshamani?

06:47 - MEENA SESHAMANI
Yeah, so for those of you who don't know, I, until I think June 25 was my last clinic day practicing as an otolaryngologist or an ear, nose and throat physician. And there absolutely are so many patients where my experiences caring for them and working with them has shaped how I approach the challenges and opportunities that we deal with in the Medicare program. There

are so many examples and where things have particularly touched me that I then bring to this role. And you know, one example, you always I think this occurs not just in healthcare, right, we always look back sometimes at previous times in our career, and oh, if only I knew… that point. And, you know, when I was in my last year of training in surgical surgical training, we had a patient who came in had a large throat cancer, we were going to do this very large procedure, you know, cutting out the tumor doing a reconstructive procedure. And I remember when I was looking at the notes, like the admission notes, this was before electronic medical record, so it was all handwritten. And I remember reading in this admission note and reading the prior, you know, chart notes that this gentleman was drinking 33 beers a day. And I remember thinking, is that like a mistake? Like, did they mean three beers a day? And I remember I went to the the gentleman, I said, sorry, you know, I just wanted to check. You know, I've read that you drank 33 beers a day, and I wanted to check. And he said, Yes, I drink 33 beers a day. And, you know, he had this huge procedure, like an all day surgery, he ended up in the ICU because we had to manage detox for alcohol withdrawal, right? His nutrition status was poor, his wound ended up opening. He had all these wound care issues, he was dependent on, you know, a feeding tube in his stomach. He didn't have family members around, it ended up, you know, there's so many moments where you think, what, what could have been done differently. And I think that's just one example of where I take that to heart when we are talking about whole person care and what does that mean? It means helping people and seeing them for who they are as a person, and not just okay, here's a gentleman who has a cancer who's coming in for a surgery. And then we just have to, you know, get him back in shape and discharge him back out into the world, right. And being able to approach how we care for the 63 million people in our program, as people who have a myriad of experiences that impact their health, who are members of their community, who might have complex social needs, along with complex health needs. So that's just one example of how things that have touched me during the course of my life. You know, I really take to heart as I am looking to serve in this role.

09:48 - NATALIE DAVIS

And now that you're serving in this role, you've been a provider and you've had many different positions outside of government within the government. What do you wish that doctors and providers knew about CMS and Medicare that you don't think that they know?

10:05 - MEENA SESHAMANI

Well, I think, you know, a lot of people say, Oh, Medicare, you know, does this does that does this other thing. There are kind of three layers to Medicare. And really, you know, with the health system. The first is the statute. So there is statute laws for Medicare that guide what can be done and what cannot be done in the program. Then from there, you have regulations. So where the Medicare statute says that we should provide care, then and make payments, then through our regulations, we determine some of those avenues. From that aspect of policy. There's enormous operations that happen, 1-800-Medicare, Medicare.gov, all of the claims, we pay the Medicare Learning Network that provides education for providers. And then you have the whole ecosystem that takes the environment, if you will, that's been created through the policy through the law, to really provide care on the ground for people. So in order to drive change, it really is about thinking about all of those layers, and in particular, our levers in that

regulatory, you know, operation space is kind of at that, you know, 20,000/30,000 foot level. And I know, again, coming back to your first question, having cared for patients having led care transformation efforts in a health system, there is a lot that happens on the ground. There are partnerships, there are workflows, there are cultural considerations. You know, I used to say I Lead Community Health in my last role, among other things, and I used to say, the first word of Community Health is community. Health care is local. And I think it's so important that we think about our work across all of those layers, and particularly for those who are caring, not only for the 63 million people in Medicare, but for the people in our country who need care, that it is so important that we have partnership, but we're learning together about what works and what doesn't that where there are opportunities to think beyond health, that providers feel that they have a support where, for example, we in CMS are partnering with the Health Resources and Services Administration so that we can make sure where there are investments in communities that that can be leveraged to improve the health of the patients that a doctor may be seeing in his or her office.

12:36 - NATALIE DAVIS

And speaking of community and full self and person, you co-authored a piece recently with the administrator and CMMI Director. And this included the line that said as women of color who have dedicated our careers to improving the health care system in the US, we know that disparities have been especially magnified during the pandemic and have put enormous strain and families and individuals. So how is your, you know, you as a woman of color, and you working with Administrator Chiquita Brooks-LaSure and CMMI Director Liz Fowler, how has that influenced, you know, your ability to leverage Medicare to really focus on health equity?

13:21 - MEENA SESHAMANI

Yeah, thank you for that question. And, you know, I'll take it kind of in two aspects in terms of my experiences. You know, first personally, I was raised in an immigrant household, I ate different food than most of the people around me. My family had some different social norms and some different perspectives of what it what is important to be able to stay healthy. So I know personally how vital it is that we meet people where they are. That we view them as people when we care for them. And not just as someone coming into a clinic or hospital with a specific diagnosis code. And this brings me to, you know, my experiences as a practicing doc. You know, it's been brought home to me time and time again, through my work. You know, there was an older African American lady when I was practicing at Georgetown with dementia, and I diagnosed aggressive salivary gland cancer for her. And her two daughters came into my clinic. And they spent quite a bit of time telling me about how their mom had moved north to create a better life for them, and what a fighter she was, and how hard it was for them to witness the progression of her dementia and to now have to make decisions about the treatment of her cancer. You know, another example like of the importance of the personal experiences and caring for people, we had a Vietnamese COVID patient who upon leaving the hospital now had to navigate his prescriptions. But he and his wife didn't speak English. And on top of that, they now had to isolate themselves from other family members. And so we were able to engage our community pharmacists to be able to support them to be able to go pick up meds to be able to explain things to them. And again, bringing it back to my own family, my parents, my aunts and

uncles, I saw how they supported my grandparents when they moved to this country to make sure that their care was sensitive to their cultural and linguistic background and needs. And so these experiences both personally for me, and, you know, through my experience, caring for others, really informs how we embody CMS's goals around health equity. Ultimately, health equity means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to obtain their optimal health, regardless of race, ethnicity, language, disability, geography, sexual orientation, or other factors. And bringing this now to the Medicare program. What does that mean? You know, we published a piece in JAMA Viewpoint where we talk about leveraging Medicare in two ways for health equity. First, thinking about our everyday operations, again, just from some of the examples that I provided. I know all too well. And I know all of you know this, too. When the system is complex, when it's difficult to navigate, when you know, things are not reliable. It's those with the most complex health and social needs, who fall through the cracks. Those who maybe don't have good English proficiency, don't have a graduate education in you know, health economics, right, don't have family members who can support. And so by making in our everyday operations, a system that is easier to navigate that is reliable, that is comprehensive, that is going to support those who otherwise would be left behind. And we really take that to heart with every single aspect of our nearly trillion dollar operations, from our oversight of plans and payers, to medicare.gov and 1-800-Medicare, where are there those opportunities that we can make the system work better for people. And then from there looking at more specific policies that we can put in place to really drive those addressing of health disparities and advancing health equity. So as you may have seen, we're soliciting comment on a health equity index so that in Medicare Advantage, we can encourage plans to really take great care of those who are dually, eligible disabled low income. Where we are thinking about how we can stratify quality data so that you can see where there are disparities to then encourage those disparities being addressed. Or you know, where we're rolling out more graduate medical education slots, specifically to rural and underserved areas, so that we can make sure that we're building the capacity of health care organizations to address disparities, because where someone trains, they learn the needs of that community, and they're more likely to stay in practice there afterwards.

18:19 - NATALIE DAVIS

So one of the things we do at United States of Care is go out and talk to people across the country. And recently our team was in South Carolina talking to seniors about barriers to access. And you know, one of the really things that came through in rural South Carolina was a story from someone of Waukee, how common it was to walk three miles as a senior to get health care, because they lack transportation, or being forced to use health care that was only close to them, and they had no other options. So that's what they were going to use. How do you think about, you know, these health related social needs of the community, of lack of access? And what are the tangible things that you think Medicare can do to really help close these gaps?

19:08 - MEENA SESHAMANI

Yeah, I mean, I'm so glad that you raised this because we absolutely need to address the social needs if we are going to improve health. And I'll give you another example. You know, in my prior work, where I lead community health, we had a woman with chronic obstructive pulmonary

disease, COPD, who kept coming back to the hospital and getting readmitted. So we assigned a community health worker to her and the community health worker went out to her house and discovered that her electricity kept getting shut off. So she had a nebulizer but because her power kept getting shut off she wasn't able to use the nebulizer and that's why she kept coming into the hospital. So the community health worker worked to get her electricity on and she was able to stay healthy and not commit to the hospital. And I think these examples demonstrate the importance of taking that more holistic approach to caring for people as people with all of the circumstances, all of the experiences that affect their health. And this is particularly as you mentioned with rural South Carolina, these social needs are particularly pronounced for people in rural areas that lack access to social services and in other underserved communities. And so this is where we are making some efforts to really be able to drive at how we address these social needs. So for example, we are now going to require special needs plans in Medicare Advantage. So these are special types of plans. For people who are dually eligible or live in an institution or have certain chronic conditions, we're going to require them to screen for social needs as part of their health risk assessments. We are soliciting common and proposing new quality measures to assess how often providers are screening for social needs and thinking about follow up. And then moving beyond screening, it comes back to what I was mentioning before with all of you. How do we create that ecosystem in which care can be provided in a more holistic way. So again, where we can foster more team based approaches to care, better integration of behavioral health with primary care, where we can create partnerships between community health and community based organizations and say, a doctor's office, that's all work that we want to keep doing. That's part of how we want to bring more people with Medicare under these more holistic care models, because that will also drive the addressing of these health related social needs, and making sure that we are caring for people in the most effective way to keep them healthy.

21:45 - NATALIE DAVIS

You know, we hear from people across the country that they want a health care system, like you said, that treats them as their whole body, that is easy to navigate, where the doctors stick with them over time. And that, you know, they get a visit and the time and attention that they need. They're not thought about as one body part versus another. And, you know, in essence, they're talking about a health care experience that really focuses on, you know, a healthier life and delivering value. In health care, we call this you know, value based care. And of course, people don't know those words, and maybe and probably shouldn't, but really are talking about the experience that they want, that matches the tool that we have, and paying for care differently innovating and care. And you've mentioned before that, you know, CMS has a vision of having everyone in traditional Medicare indicare arrangements that really do account for the quality and cost by the end of the decade. And so how, how are you guys thinking about the promise of value based care? How do you think about communicating this to providers and to beneficiaries? So we really can, you know, move closer to that healthcare system that people want?

22:58 - MEENA SESHAMANI

Yeah, well, I do think Natalie, that if you just pull someone on the street and say, What do you think about value based care, they'd say, what? It's so important. Health care is very complex. And it's very personal. And I think as we are driving change, it's so important that we engage the people who are doing it for as we're having those conversations about how to change care. And that requires talking in a way that people can understand because not everyone is a health policy long. So being able to talk about preventing problems before they begin, being proactive with care instead of reactive, being able to take responsibility for someone's health and well being outside of the four walls of a doctor's office or a hospital room. And the importance of how taking this more integrated team approach can really make a difference with better health saving lives, fewer medical errors. You know, so when you mentioned about, you know, people don't want to just be seen as a body part, right? So I am a specialist. I specialize in, you know, the head and neck area. My medical assistant got an award, because there was a woman who had come into my office for something related to the head neck. My medical assistant in looking at the chart saw that this woman had not had a mammogram in a while. She asked while you're here, do you want me to go ahead and schedule your mammogram? And that mammogram found early stage breast cancer. So I'm a head neck surgeon yet through the care that my team provided my medical assistant we were able to identify early breast cancer and essentially help this woman to live a healthy life. Right. So how do we how do we further that? And I think that's where our goal to bring 100% of people in traditional Medicare under one of these Accountable Care relationships where you are thinking about care more holistically. That's where that is so important, you know, and we want to do this by 2030. And that means really trying to drive these kind of more holistic models, these accountable care organizations, for example, where groups of providers are then held accountable for quality and for the cost of the care that they're providing and encouraging more team based approaches. But in order to do so it comes back to what you're saying, Natalie, to really engage the people, that all of this is for the people who are at the center of all of this work, so that they understand what we're trying to do. And then they engage to tell us what it is that, you know, that they want and need. You know, one more example, I visited an accountable care organization in New York, that cares for an IDD population, intellectually, and developmentally disabled population. And they are doing amazing things in terms of linking the hospital, the clinic, the group home, because a lot of their population lives in group homes, you know, how they're sharing data, the quality improvements? And I said, so how do you explain all this amazing work you're doing? How do you explain it to your patients and their family members. And they said, Oh, well, we just tell them that by doing what we're doing, we're going to prevent them from sitting in the ER for multiple hours. Like they distill it down to what really matters to people, like, you know, everyday people may not understand all of these complex data, dashboards, et cetera, et cetera. But they can understand very tangibly that by keeping their family member healthy, they're not going to be sitting in an emergency room lobby waiting to get care, because their loved one is going to be kept healthy and happy. And, you know, people feel like they have someone's arms wrapped around them caring for them. And that really stuck with me, I think that's how we have to approach all of this work. And this is also where the partnership is so important, where there are trusted voices in the community that can really help us to bridge these gaps, to be able to have these honest conversations and really make sure that we are keeping the people we serve at the center of all of this work.

27:11 - NATALIE DAVIS
Yeah, we've found the same that talking about the experiences that people want is really is the kind of way to talk about how to, you know, change and fix our healthcare system. You know, the most urgent thing that we hear from people across all demographics is the importance of making prescription drugs more affordable. And we you know, we're continuing to urge Congress to act on this issue, and we know it cannot go on unaddressed. And so how are you thinking about it from your perch? What role does CMS have to really address this important issue?

27:45 - MEENA SESHAMANI
Yeah, the high cost of prescription drugs remains a significant challenge for the nation, and for people with Medicare, who rely on them to stay healthy. You know, we've been talking a lot about advancing the health of our country. But if the prescription medicines that people need to take to stay healthy are expensive or unaffordable, this presents a huge barrier to making the kind of progress that you and I have been talking about, you know, so far. And, you know, again, I had a woman who I was caring for who was on Medicare, had this ear infection that would not get better. And I remember getting on my smartphone with her on Good RX trying to look up second third order antibiotics that she could afford to take. I mean, this really does strike home. You know, as a former leader in a medical system, as a provider. As an economist. I know how unaffordable drugs can impact the patient and cause negative consequences that ripple through the entire health system that wants to serve that patient. And in particular, as an economist, I do believe that affordable drug prices are not a trade off for innovation. Medicare negotiation can lead to affordable drug prices, and also foster scientific innovation by establishing incentives for innovation that produces the cures we need. So as you know, a goal of the Biden Harris administration is to foster innovation to increase competition to improve the market environment. And we can do all of this in pursuit of reduced drug spending for consumers and throughout the healthcare system. And President Biden has charged CMS in his competition executive order to explore payment models that support increased utilization of generic drugs, bring more savings to Medicare and Medicaid. And I think as you all know, tackling these problems is complex. There is no silver bullet. But what we want to be able to do is you know, three fold, use data to increase transparency. So for example, we annually published drug costs on Medicare and Medicaid in drug spending dashboards, because where you can see things where you can measure that's where you then have opportunities to improve. Number two, we want to ensure access to innovative drugs that drive value and improve health outcomes. So for example, we allow Part D, the drug plans in Medicare, to provide lower cost sharing for specialty generic drugs. We also then number three, want to improve affordability, lowering patient costs, we want to reduce ineffective program spending. So here, as you may have seen, we recently finalized a regulation that would require where plans are getting price concessions from pharmacies, that that reduction in price translates down to the point of sale for the person who's getting the drug, so that they have reduced cost sharing because previously, that price concession would happen between the plan and the pharmacy, and the person who was getting the drug would never see that savings. So again, where there are opportunities to increase transparency, and to increase affordability. And some of this, again, comes back to our theme of there are regulations. And

then there's how things, how care is provided on the ground. And so where there are opportunities for us to provide more education to engage in the sharing of best practices. You know, for example, we're working with the FDA to share provider education materials, that can give options for how providers can reduce drug costs for their patients. So kind of taking this multi pronged approach around data, access, and affordability to really help drive the value in drugs for people with Medicare and in the healthcare system writ large

32:00 - NATALIE DAVIS
Great and reminder to people to send in any questions you have through the Q&A function. Meena, switching gears a little bit as we think about, you know, the impact that the pandemic has had on how we access care, and the real use out of necessity for virtual care. And as we thought about it as an organization, you know, to us virtual care was only important if it was increasing access to care for people who historically have lacked access to care. And, you know, we are finding that as we're talking to people, and especially older adults, they are growing more comfortable with the concept of virtual care, preferring a blended approach where they can access in person as well as virtual to meet their needs. Some continue, of course, to rely on phone based virtual care due to technology issues, we were our team just in South Carolina, there was a woman who said, The only thing I don't like about virtual is you got to have internet. And so as we think about this, you know, the shift in how we access care, the eventual end of the public health emergency, what is how are you thinking about what virtual care will look like for people that are on Medicare going into the future?

33:13 - MEENA SESHAMANI
Yes, this is an excellent area to to have a conversation, you know, because again, as you have said, Natalie, and as many of you know, the pandemic created an incredible amount of change in the healthcare system, you know, at the outset to ensure that we could continue to provide care virtually to protect Americans from COVID-19 and maintain access to health care services. And also, as we've been talking about with team based approaches to care, we know that those who employ community health workers, case managers, there were opportunities to leverage that to pivot to really be able to keep communities healthy, addressing food issues when people had to isolate with COVID, et cetera, where having trusted voices when bringing vaccines to communities really made the difference in how we were able to address and continue to address the pandemic. And so telehealth is obviously a huge piece of this, as you know you mentioned, Natalie, and in fact, a recent report from HHS found that in 2020 telehealth visits and traditional Medicare increased 63 fold to 52 point 7 million visits. And this was a result of public health emergency waivers and new authorities that were granted during the pandemic again, flexibilities that helped maintain access to care and supported providers when in person visits declined dramatically so the providers could still provide care and stay in business if you will.

34:57 - MEENA SESHAMANI
Many of those flexibilities have been extended for five months through the Consolidated Appropriations Act of 2022. And also following congressional action, we have been able to make telehealth payments permanent, for behavioral health for even after the pandemic,

because, again, with that HHS report, the largest increase in telehealth utilization was in behavioral health. We have good evidence about how behavioral health works, we know that we have a behavioral health crisis, that we have access issues and where there are opportunities to be able to bolster behavioral health that is critical for the health of both people in Medicare and people outside of Medicare. And so we have made permanent telehealth payments for behavioral health, including audio only. But I think moving forward from here, you know, how do we look ahead to lessons learned from the pandemic? And you know, again, I'm going to come back to one of the first questions you asked me about, what should people know about Medicare, there's statute, there's regulations, there's how, you know, the ecosystem cares for people on the ground. And so in that regulatory environment, which is where you know, where I sit, where we have that ability to, you know, to look at what we can pay for and support, we really are evaluating innovations, such as telehealth through the lens of how they can advance the vision for Medicare, our shared goals as we started Natalie, with advancing health equity, driving high quality, person centered care, promoting affordability and sustainability of the program. So the example you gave really gets to that equity bucket. You know, the HHS report that I mentioned, found that Black Medicare beneficiaries and those living in rural areas had lower telehealth use compared to their white and urban counterparts. A more recent report found that among the telehealth users, Black and Latinx patients were significantly less likely to access video services as well as those who had lower incomes and less education. So what does this mean, to leverage new technologies, we have to ensure that they advance access while also addressing existing disparities and not exacerbating them or causing further harms. So this is where the example you gave about needing to have better internet, we have to consider broadband access, the cultural and linguistic appropriateness of services, the familiarity and comfort with technology among a very diverse population of people that Medicare serves as we are developing and implementing such innovations. And specifically on the broadband point, you may have seen, the President and Vice President recently announced as part of the bipartisan infrastructure act, that there's going to be the affordable connectivity program, which allows 10s of millions of American households to reduce their internet service costs by up to $30 a month and up to $75 a month in tribal lands. And the administration is also securing commitments from 20 leading internet providers that cover more than 80% of the US population, to either increase their speeds or cut their prices. So again, what you called out Natalie is absolutely an area that requires a whole of government approach to be able to make sure that the innovations that have really launched during the course of the pandemic can be leveraged in the manner that can most address the needs that we have seen through the course of the pandemic and really drive that future of Medicare. And I know we spent a lot of time on equity related to telehealth again, in part, you know, because of the example that you provided. But I, you know, I also want to point out that our buckets of you know, how we drive innovation for high quality, person centered care how we think about affordability and sustainability of the program, that is also front and center as we're evaluating innovations, you know, where are there innovations that really change the way care is provided so that people stay healthy, they don't have to come into the hospital sick, and you end up keeping them healthy, improving outcomes, providing better care, and saving money overall, you know, we really want to engage with innovators in this because there is such an opportunity to leverage that for these common goals that we have.

39:43 - NATALIE DAVIS
When we've gone out and talked to people about what are the targeted solutions, what are the changes they need in the health care system to make an impact on their lives? We've talked about virtual care, we talked about access to insurance. We talked about drug prices, the one that also rose to the top again across demographics was this idea of caring for a loved one at home instead of putting them in Institution and a real desire to help people that are caregivers, whether they use that word or not caregivers care for their family members or others at home. And, you know, I think about, of course, I think all of us think about Medicaid and the CMS or Medicare at CMS is really about caring for the beneficiary. How are you able to think about the CMS and the role of caring for those unpaid caregivers who are caring for the beneficiaries, knowing that the health of the beneficiary of course is reliant on the caregivers that they have at home?

40:40 - MEENA SESHAMANI
No, I mean, I think that's absolutely right. And I will say, family caregivers play a critical role. I know this as a daughter, with parents on Medicare as a mom of two kids. And as a doctor, I mean, just the examples that, you know, we've been talking about today of, you know, the elderly lady with salivary gland cancer, where I was talking to her two daughters, or the gentleman who didn't have family members and had this enormous gaping neck wound, right. I mean, it is so important that we take into consideration and really support that ecosystem that is caring for the people who have Medicare and beyond. And this is something that we're thinking about. We're very focused on as we think about these holistic care models that we're working on. Where are there opportunities to make sure that we are connecting the dots, for example, where there is a provider who is engaged in these holistic care models? Can we create those partnerships with the Health Resources and Services Administration, with the CDC to bolster public health? And in fact, we're talking with the Administration for Children and Families and people might say, why is Medicare partnering with the Administration for Children and Families? Well, it's because through the programs that ACF runs, they have a network of community supports that can be leveraged for caregivers, for people with Medicare, where you're caring for a whole family, and where can you provide that support and those resources to the caregivers so that you can keep everybody healthy and really enable everyone to be cared for by a more holistic system.

42:24 - NATALIE DAVIS
So you all have a very bold vision for Medicare. And for the role, CMS has always had some type of action from Congress, the Medicare Hospital Insurance Trust Fund is projected to be insolvent in 2026 that soon, how do you really think about balancing these ambitious agenda with a looming financial reality?

42:47 - MEENA SESHAMANI
Well, I think that our ambitious agenda actually helps. Because again, one of our strategic pillars is around sustainability of the Medicare program, and where we can think about providing care in a different way that really provides better care, has money spent in a smarter way, and

improves the health of populations. That's really ultimately our goal. And as you mentioned, I mean, the Medicare Trust Fund solvency is incredibly important. It's a long standing issue, we will continue to work to ensure that no one, no current or future Medicare beneficiary has any disruption inaccess to care, and that the program is there for future generations. So then how are we working in that regard to extend the sustainability? It comes back, Natalie, to some of the things that we've been talking about today. Where can we improve affordability of prescription drugs? How can we partner with providers to improve quality of care while achieving savings? So the accountable care organizations that we've been talking about the program that a lot of them are in the Medicare Shared Savings Program in 2020, they saved the Medicare program, almost $2 billion, while hitting all of the quality metrics, where can we further test innovations, for example, through the CMS Innovation Center, again, looking for ways that we can improve quality of care and reduce costs? How can we reduce fraud, waste and abuse in the Medicare program? And then, you know, I think one other big one other aspect to talk about is Medicare Advantage. Where can we increase data and transparency so that we can see \how the Medicare dollar is being spent and make sure that that is providing value to the people that are enrolled in Medicare Advantage. So you may have seen recently where we reinstated medical loss ratio reporting, that is where you have to report how the dollar is spent on care versus other activities. And we are extending that reporting to supplemental benefit. like food, housing, transportation, so that we can see how that Medicare dollar is being spent. This is also where our oversight comes into play where we're reinstating network adequacy, looking at prior performance and not accepting applications, if there's poor performance, you know, so being able to leverage our oversight as well, to make sure that where the Medicare dollar is being used, it's being done in a way that really serves those 63 million people that are at the center of everything that we do.

45:33 - NATALIE DAVIS

And how we have a question from the audience of how talking a little bit more about the innovation opportunities in the Medicare space from CMS, and what incentives are available to be leveraged to really drive the innovation that we've been talking about that's needed?

45:49 - MEENA SESHAMANI

Yeah, that's a great question. And I would say there are two aspects to it. First, there's what we've been discussing around just in general, moving the health care system away from fragmented episodic care, to thinking more holistically about someone's health. So where you have people engaged in that team based care where, you know, some of the examples that we've been talking about today, where you're thinking about the electricity issues, or you're thinking about transportation, where that spurs innovation because where you can keep people healthy, you can address the needs that they have, avoid unnecessary utilization down the road, that is the Win Win, that innovation can really drive and where we create these holistic care models that encourages that, and rewards that both from the health outcome side and the cost and savings outcome side that can really drive a lot of these innovations. Then the other side of it is in more of the nitty gritty in terms of where we have, you know, for example, add on payments to encourage, you know, adoption of certain technologies. So, you know, we are constantly looking at where there are technologies that demonstrate substantial clinical

improvement to see, you know, is this an opportunity where there should be some additional payment for a few years as this is kind of gaining full, to then incorporate more writ large into the payment mechanisms of our program? So, you know, we look at innovation through kind of both of those avenues.

47:22 - NATALIE DAVIS
Alright, this next question means you might need a pen and some paper and we need you to draw a pie chart. Alright, it's actually a really interesting exercise. So if you think about the portion of health inequities, and I'm going to give you a couple of options to think about which ones do you think have the most influence on inequities, so structural issues, like language barriers, or perhaps systemic racism, training issues and sensitivity around bias of providers and care in our healthcare system, three affordability issues that disproportionately hit some communities, or access driven by lower payments for people caring for low income populations. And maybe there's a pie piece of the pie that you would add there. But those are the four offered and how you think about which ones have the most impact.

48:19 - MEENA SESHAMANI
I mean, I think what has the most impact is how all of those interrelate with each other, as well. So where you have someone who, for example, might have a language barrier, that then makes it difficult for them to potentially navigate a complex system to see where there are financial resources that could support them to be able to access care, where then if they don't have those financial resources, it is hard for them to get care. And it is hard for the people who are caring for them to be reimbursed for what they're providing. So I think it actually those are pieces of that overall ecosystem that we really need to try to change where we can improve language access so that people are able to navigate better, where we can make the program easier to navigate so that people can get access to supports that are available. Like for example, Medicare Savings Program provides financial resources for low income seniors. And when I came into my role, and we were starting our Medicare open enrollment, I learned that only half of seniors eligible for this program were enrolled. So this is an example coming back to kind of those three layers statute, the regulations and the programs and how things play out on the ground. You can have a wonderful program if people don't know about it, that's going to limit the impact of that program. So we did a pointed effort during open enrollment to increase awareness of the Medicare savings program, and we increased enrollment by you know, I think 800,000 people. So again, where we can then enable people to utilize services and supports that are available. And then where that can then translate to training for providers being able to support them when they're caring for underserved areas, you know, it comes back to the graduate medical education slots and where we can bring resources to bear. And with our holistic care models, we are thinking about specifically supporting providers in rural and underserved areas so that they can participate in these more team based approaches to care because we we know that it works and that it will help them to take better care of the people that they serve,

50:40 - NATALIE DAVIS
So you're just going to the whole pie.

50:44 - MEENA SESHAMANI
What is it the sum, the sum is greater than what the whole is greater than the sum of the parts?

50:51 - NATALIE DAVIS
I've just something you mentioned throughout this is the real and it's something that I've become there, my career I've been obsessed with ispolicy is only so good as the implementation. And if it's not implemented, where it works with people where they have the knowledge of it, where it meets their needs. You know, policy doesn't get us the change that we need if it's not implemented well. Another question that we've had is really about Medicare Advantage, and how do you how does that fit into how you think about Medicare as a whole? How are you thinking about Medicare Advantage?

51:23 - MEENA SESHAMANI
Yeah, so Medicare Advantage is one piece of the puzzle of the overall Medicare program. So you have traditional Medicare Part A and B, A, for institution care B, for more, you know, provider specific care, outpatient. Then you have Part C, which is Medicare Advantage, Part D for drugs, and you have supplemental health insurance as well. And really all of that together comprises the Medicare program. And having all of those aspects to it, provide options for people because again, 63 million people is pretty diverse. And so where can you have good options for people to see what works for them. The key to that is making sure that all of these pieces are driving towards our shared goals, where we are getting the most that we can out of the Medicare dollar, where we are advancing equity and addressing all of the issues interrelated issues that we were just talking about, where we can really utilize innovation as a vehicle for that high quality, Whole Person Care and Medicare Advantage plays an important role in that. And I think, again, to come back to what you were saying, Natalie, you can have all of these wonderful programs. The key ultimately is how do they get utilized? And how are they leveraged on the ground. And that's why it is so important for what we do, that we keep the people we serve at the center, we make the health care system more navigable, easier to understand. I mean, healthcare is very complex and very challenging. So I mean, you may have seen, we unveiled a series of updates to the medicare.gov website to make it easier to use, where we're trying to use simpler language where we can answer complex questions that people have about their coverage and provide step by step guidance for people who are new to Medicare to be able to understand you know, what their coverage options are, how it works. Also, for the first time, we're including Medigap plan costs and coverage, that supplemental side so again, people can see the full spectrum of what their options are in the Medicare program. And that navigability, transparency, plain language that is so central to all of the policy work and all of the operations that we do so that we can make sure that whatever improvements that we are trying to make, number one is keeping the people we serve at the center and incorporating you know their perspectives. And number two is something that then people actually know about and can utilize.

54:01 - NATALIE DAVIS

And the last couple of minutes that we have Meena I'd love to open up to you and say what questions should I be asking of you right now? What else do you want to make sure the audience knows about?

54:14 - MEENA SESHAMANI
I mean, I think one thing is how can all of you help? Right? I mean, I think we've all seen how much opportunity there is to improve health in our country in so many ways every day. And I think everything that all of you are doing in all of your different ways to really further that dialogue to further that work is so critical for us to collectively be able to succeed. You know, like when we rolled out our over the counter Testing Initiative for COVID first time in the history of the Medicare program, paying for an over the counter service or test at no cost to people with Medicare, that would not have been possible without the tremendous partnership that we had, with pharmacies, with providers, with beneficiary groups, with consumer groups, with plans with employers, it really is it really does take a village. And it's so important that everybody is working together that we are hearing your thoughts of the good work that you're doing, where there are opportunities to improve, where we can share, you know, where we're thinking we can do things, it's so important that we have that dialogue, and that we have that partnership, because that's how we're really going to derive this change.

55:39 - NATALIE DAVIS
Great. Well, I want to thank you, Meena, for your time today, as well as your service to our country. And I know you're working, r&r with the amazing public service crew that really keeps Medicare and our and CMS functioning and our health care system. And so thank you for your time and for your dedication to our health care system. I want to thank everybody for joining today, for being a part of this conversation. You can learn more about United States of care at United States of care.org. We'd love to hear from you. We'd love to work with you. And if you find it called to support us financially. This is how it keeps our sustained work that we can do across the country to make changes for people. So thank you, everybody, and I hope everybody has a great day.

56:30 - MEENA SESHAMANI
Thank you