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Marianne O'Hare: Welcome to Conversations on Health Care. This week, we welcome CMS Administrator Chiquita Brooks-LaSure, on the President's proposed expansion of support for mental health and community health centers in his annual budget.

Chiquita Brooks-LaSure: We have a department-wide focus on mental health, really looking across all the agencies to really see what we can do.

Marianne O'Hare: Lori Robertson joins us from FactCheck.org. And we end with a bright idea, improving health and wellbeing in everyday lives. Now, here are your hosts Mark Masselli and Margaret Flinter.

Mark Masselli: CMS, three letters that make up an important acronym. For those in our audience who know what CMS stands for and does, we have the person in charge as our guest. It makes over 1 trillion in health care expenditures annually, and is the largest health care payer in the entire country.

Margaret Flinter: And Chiquita Brooks-LaSure is the agency's administrator. During the Obama years she played a key role in guiding the Affordable Care Act through passage and implementation. Brooks-LaSure has decades of experience in the Federal government, on Capitol Hill. She's also the first Black woman to lead the agency. Welcome.

Chiquita Brooks-LaSure: Thank you. It's a pleasure to be here.

Mark Masselli: Welcome, again, to Conversations on Health Care. You know, President Biden has just released his proposed budget for the next fiscal year, and of course now Congress will weigh in. We know there are some important dollar amounts devoted to community health centers, mental health, HIV prevention, and other initiatives. I wonder if you could take our listeners through the budget and the thinking behind it.

Chiquita Brooks-LaSure: So, thank you so much for the question. We are so excited about this President's budget. As we all know, starting with mental health, that COVID-19 pandemic has just put such a strain on the mental health of Americans across the country. And all of us with children certainly know how much our nation's children have really suffered during this time period, and certainly children who are in underserved communities are really at a crisis level. That's just the tip of the iceberg. And so we have a department-wide focus on mental health, really looking across all the agencies to really see what we can do. And I would say about CMS in particular, our focus has been, and it's going to be, on the programs we serve.

So, as you mentioned, I like to say the three Ms Medicare, Medicaid and CHIP, Marketplace Coverage. So, we are asking Congress for additional authority in the Medicare program, and you will see from us continued emphasis in Medicaid and CHIP particularly around child health, pediatric care, and certainly in marketplace, so in commercial insurance, making sure that there is parity between mental health and physical health. So that's one piece that's a huge priority of the entire department, and certainly us at CMS.

Another priority is nursing home care. And as part of the State of the Union, the President released, along with us, a charge to really look at our care in our nursing homes, and we released detail on in our budge, asks for additional dollars from Congress to make sure that we are able to really survey nursing homes and help them come into compliance with the rules so that our nation's seniors and people who are the most vulnerable are well taken care of.

Those are two priorities. But health equity is a key priority of this administration, and we have all been working very hard to advance health equity across our programs. I think a key part of our ability to address this is for CMS programs, the financing side, to really work with the other agencies, whether with CDC, to partner with NIH, to partner with HRSA, to partner with CMSA, all the other organizations here to really try to move the needle on a whole host of issues like maternal health. So that's really what this budget is really reflecting, our work of trying to work together to address some of the most pressing health care issues facing our nation today.

Margaret Flinter: Well, thank you for sharing those with us. Those are such critical issues to all of us who are engaged in health care, and in the communities we are seeing exactly what you are describing. I wonder if I can just get a question right upfront that's very much on people's minds right now. Health and Human Services Secretary Becerra has extended the Covid Public Health Emergency Declaration until April. We are all reading about the rise of the new Omicron subvariant BA.2. And I wonder, having laid out your health worker vaccine mandate for the institutions and organizations and practices that you certify, or are responsible for, how long do you think you are going to have to continue that health worker Covid vaccine mandate? We know the Republicans would like those orders to end right now, but what are your thoughts as you look at what's coming down the road for us?

Chiquita Brooks-LaSure: Well, I would say requirements often help people react and

respond. And I would say what we have seen is that the response to the requirements has really lifted up institutions and workers following the requirements. We are seeing booster rates and vaccination rates really growing, and so I think that there was such a focus on what are going to be the hammers that we are going to use. But really what our approach has been, has been to work with hospitals and all sorts of facilities to help them come into compliance. And I think it's working very, very well.

To your larger question about how long are we going to be doing this, I think that people, be scientists and all of my colleagues over on the other side of the House, are working really hard to try to make sure that we are responding to the science from our perspective. We will be prepared for the public health emergency to end at some point. But, as you probably saw, we put out guidance to the states around when the public health emergency ends not anticipating that it will end in April or X day or Y day, but really trying to make sure that everyone is prepared. And we will do the same for providers and others who are waiting for our guidance on some of the other emergencies that expire when the public health emergency ends.

Mark Masselli: You know, Administrator, I want to stay on the topic of the public health emergency. The CMS is asking states to explain how they will handle eligibility enrolment when Medicaid continuous coverage, that began during the pandemic, comes to an end. And as you know, there are nearly 85 million people enrolled in Medicaid, all who could suddenly have their eligibility redetermined. I think it's fair to say that this could result in many Americans losing coverage. I wonder if you can weigh in here on your thoughts.

Chiquita Brooks-LaSure: Our entire agency is focused on what we call the great unwinding, and we are very focused. And when I say 'the entire agency', we are very focused on making sure that we maintain the gains in coverage. Whether people stay eligible for Medicaid, or move to marketplace coverage, or Medicare, or commercial insurance, we are working very hard to make sure that we don't lose the gains that we have seen under the public health emergency. And that absolutely includes working with states. So our team that focuses on Medicaid, is very closely monitoring and talking to states about how they are preparing, and really trying to make sure that we keep the gains that we have experienced. That said, of course states have the ability to make decisions. It's a shared responsibility between us, and so it's something that we have a close eye on.

We are also working with state-based marketplaces, so the other side of the House, to make sure that we keep coverage. A key part of holding on to the gains is really the subsidies that are in the American Rescue Plan. Because what we saw during this open enrolment, were real gains for the people who are right above that Medicaid level, and as we all know that a lot of our coverage, it's the leakiest between Medicare and marketplace. And so I think that's actually a big part of the story about how do we hold on to these coverage gains, really having those subsidies makes a huge difference.

Margaret Flinter: Well, Administrator, I wonder if I can get another kind of specific question in that we are hearing a lot about particularly maybe from the folks in our audience today in the community health center space. Who are struggling with the nature of the Good Faith Estimate that's part of the No Surprises Act, they already are managing sliding fee scale requirements, getting those details to patients, and they are asking if CMS is going to provide additional guidance to them about how to maybe manage and simplify all these rules. Anything you would like to say about that?

Chiquita Brooks-LaSure: So my favorite response during the Obama years was it's coming soon. So, that's my answer, it's coming soon. Now, we definitely are hearing about the need for more clarification, and the team is working very hard to get all of the additional guidance that's necessary.

Mark Masselli: Great. You know, each new administration makes changes. And we know CMS has been adjusting policies enacted by the Trump administration. You are stopping states from charging monthly premiums to newly eligible Medicaid enrollees. And I know Georgia has a lawsuit against CMS saying this change is "an arbitrary bait and switch of unprecedented magnitude". Would you like to comment on the policy that you are trying to drive with these important changes?

Chiquita Brooks-LaSure: Yeah. So, broadly I would say that we, the administration, is firmly committed to making sure that we maintain the coverage that people depend on. I mean Medicaid is life-changing, life-saving. I had the privilege of being on a virtual call right when Missouri had expanded coverage, and got to hear from a woman who really was talking about her own experience of cancer, and how this was changing her life, because now she was going to have coverage. I didn't go anywhere during my time in the Obama years without being thanked by someone saying how it had affected their lives, changed their lives in many respects.

So, for Medicaid, we want to make sure, particularly during a

pandemic, that people had access to affordable coverage. And so that's what we are doing. We are really encouraging states to expand. We are encouraging states to move in innovative ways. We need to make sure that people can afford that coverage.

Margaret Flinter: Well, Administrator, through these last couple of very difficult years, health equity has been very much on the minds of all of us in health care. CMS Innovation Center, which looks to enhance health care quality and innovation, as the name suggests, has included advancing health equity as one of its key objectives. Tell us about this focus and what is the CMS Innovation Center looking to do with this focus.

Chiquita Brooks-LaSure: I am so excited about our agenda at CMS. And I would say that the Innovation Center has a charge, and it's been focused on really trying to make sure we are thinking and testing models that will save costs and hopefully improve quality. The Innovation Center has had 10 years of experience, and what we are really trying to do is make sure that the person's experience is at the core of what the Innovation Center is doing and how we're thinking about it. And there is no more core thing to that than making sure that we are improving health equity. And not that it's an afterthought, as I think it has been for many, many years.

We are really trying to think about how do we bring in a stronger lens of making sure that the innovations are focused on the underserved, and by underserved, you know, we have adopted a health equity definition for all of our programs at CMS, really making sure that every individual has a fair and just opportunity regardless of the list of things that can keep you from that, which can include race and sexual orientation, and socioeconomic and geography. We are really trying to make sure that our programs are actually working positively to advance health equity, not that we hope it's a byproduct.

And so, as part of that, we are including in our models a requirement on equity, plans, how are you going to try to address underserved populations in our latest announcement on ACO REACH where we are actually going to pay a differential based on the entity's ability to move the needle on underserved populations. And that includes not just focusing on the people, but on the organizations like community health centers serve the underserved.

So that's a big piece of making sure that we achieve health equity. It's not just about making sure there are people of color, etc. included in our data and what have you. It's making sure people with cultural competency, organizations that actually are

in the communities where people need to be served, are actually included in whatever innovative things we are doing. So that's a big part of ACO Reach, as well as our broader strategy of really making sure we are thinking about the organizations that serve the people who're concerned about achieving optimal health outcome.

Mark Masselli: So good to hear that they are using the equity lens as they look at everything that they are doing. So, we applaud their work. I want to talk a little bit about the ACO REACH Program. The Biden Administration has changed the direct contracting model after pushback from progressive lawmakers, but the House Progressive Caucus still wants to get rid of it, now known as ACO REACH. What do you say about their criticism that this Accountable Care Organization model just adds an unneeded middleman?

Chiquita Brooks-LaSure: Well, pulling back and really looking at what's happening in the Medicare program, is really important that we put all of our initiatives in context, which we are really trying to do. When you look at what's happening in the Medicare Program overall, Medicare advantage is growing, and it is able to provide some services that we want to make sure that people who enroll in traditional Medicare are able to receive. And one big piece of that coordinating care where we want to see entities having incentive to make sure that we are looking at the whole person.

And so, as part of some of the changes that we made with ACO REACH we really wanted to make sure that a provider perspective was stronger in the ACO REACH. So, having more providers as part of the decision-making process was a big part of some of the things that we wanted to do. But I would say that we look at models like Accountable Care Organizations and we have learned we have models in different parts of the program that when done well can really make a difference in terms of people's lives. And so we want to make sure that we are preserving some of those important elements and really building on those.

Margaret Flinter: Well, it's hard to talk about health care without talking about money of course in our country. But, one of the areas that has never maybe quite made sense to everybody as anything more than maybe historical accident, is the difference in the payment schedules for Medicaid and Medicare. A physician providing the exact same service to somebody covered under Medicare or Medicaid has possibly very significant different payments. The work of nurse practitioners for the last couple of decades has been reimbursed to 85% of the physician pay schedule for the

same service even as we emphasize team-based care and multidisciplinary teams. What are your thoughts about approaching some of these longstanding inequities if you will in the payment system? Is that part of the charge to the organization at this point?

Chiquita Brooks-LaSure: Yes. I would say these sometimes -- you know, a lot of the team, they would say -- they would often hear from me how much of this is in the [inaudible 00:17:50], how much of this is how we have done it, and really trying to tease out what do we have authority for, and what can we do under our own authority. I do think that we as an agency are really focused on making sure that Medicaid is meaningful coverage. So, whether it's Medicare or any of the other Ms, we want it not to be a card in your pocket, but really make sure that it is means so you can see your doctor.

And as part of that, we have a Medicaid Access Request for Information where we are really looking at making sure that we are talking and understanding what's happening in the Medicaid program in terms of people getting adequate access to care, whether it's making sure the benefits are there, or making sure the providers. And certainly in the Medicare program we will continue to look at what our levers are. We, recently in our physician fee schedule, included an update that's going to integrate more information about a variety of ways that people get paid. That's the first update in 20 years of including some of this additional information. So we are certainly looking at what our levers are, and thinking about ways that we can try to address payment, balancing that with what our statutory authority is, and being good stewards of the trust funds.

Mark Masselli: Well, I want to pull the thread on what we can do on our own authority, particularly on the issue of Graduate Medical Education Payments, which fall under CMS. The recent National Academies of Science report on primary care highlighted the need for the use of interprofessional teams, and I am wondering can CMS make changes to those Graduate Medical Payments. Right now we can only pay for the physicians and the dentists. How about the rest of the team? Is this an idea that is within your purview, or does it require legislative action?

Chiquita Brooks-LaSure: So, the team isn't sitting with me but they would kick me under the chair if they were to say don't you dare commit to anything in public. So, I will have to say that I will look into it. I will say that we have, when it comes to GME, a lot of statutory requirements. We do pay hospitals and that's usually our lever, but happy to look at some of these ideas and see if there are

things that we can do.

Margaret Flinter: Well, perhaps then I am going to rephrase my next question, or they will be coming and kicking you under the table if I ask you about reimbursement for community health workers. But I am really at least as interested in asking you about your thoughts on this. The community health workers' probably a group that maybe wasn't so much on the radar of CMS until we started moving much more in the direction of moving the needle on outcomes and value-based plans on the community engagement. What's your thought on where community health workers fit into the kind of Medicare or Medicaid family at this point?

Chiquita Brooks-LaSure: I would say there is sort of new understanding of how important the community is to delivering health outcomes. I really got more of a perspective on that right before I ended up being CMS administrator, really trying to work on some of these issues like maternal health, like equity, where you really do need the village to help. And then of course I think we all got an education when it came to COVID-19 of just hearing about people need to hear from trusted partners, and a lot of times those trusted partners are people in their communities. Or they need the help from the [inaudible 00:21:43] or the person that connects them to the other supports, and just how health is one, and probably one of the biggest determinants of how you are going to be able to live your best life, and just how integrated all of that is.

So, we are certainly looking at ways that we can integrate community health workers into our payment processes. So what works through the Innovation Center of looking in through the Innovation Center, we have been able to have more flexibility and we will continue to look at our ability to do that in Medicare. And certainly in Medicaid states have flexibility to do those things. We recently approved a waiver in California that went further in terms of allowing some of those supports, and certainly we will look at other state initiatives as well.

Mark Masselli: Well, thank you Administrator Brooks-LaSure for these insights. And thanks to our audience for joining us for this talk about health care, how it's paid for, and all the issues wrapped up in these decisions. You can learn more about Conversations on Health Care and sign up for our email address at www.chcradio.com. Again, Administrator, thank you for all the work you have done over a lifetime, and we appreciate you taking time with us today.

Chiquita Brooks-LaSure: Have a great day.

Mark Masselli: Alright. You as well.

Margaret Flinter: Thank you so much.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. Politics. Lori, what have you got for us this week?

Lori Robertson: The Centers for Disease Control and Prevention recommends that children get four doses of the polio vaccine, with the last dose given between ages four and six. But Representative Marjorie Taylor Greene, when speaking against a potential fourth dose of the COVID-19 vaccines, wrongly suggested that the CDC doesn't recommend four shots of the polio vaccine. Greene, a Republican lawmaker from Georgia, said that Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases, was "recommending a fourth COVID vaccine shot." She then said that many of us were vaccinated against polio as children, adding, "I have never seen the CDC coming out saying oh, you have got to get your second polio shot, you have got to get your third, you have got to get your fourth," saying, "I think the question we all should ask is when does it stop and when are enough vaccines enough."

The CDC had not yet recommended a fourth COVID-19 mRNA vaccine shot to the general public when Greene spoke. It only had done so for those who are moderately or severely immunocompromised. On March 29, however, the FDA authorized a second booster, or forth shot, of the Pfizer-BioNTech and Moderna COVID-19 vaccines for those age 50 and older, and for those with immune deficiencies. The CDC's advice on the matter was expected to follow shortly.

But as for polio, the CDC does in fact say you should get a second, third and fourth shot as a child. The CDC says that the inactivated polio vaccine, the only polio vaccine administered in the US since the year 2000, is given by shot in the leg or arm. The CDC recommends four doses, one dose at age two months, with the subsequent doses at ages four months old, six through 18 months old, and four through six years old. Adult, who have never been vaccinated against polio, and who are at higher risk of getting the disease due to their work or travel, should get three doses, the CDC says. As for Greene's reference to Fauci, he

said on March 17 that the vulnerable may need that fourth dose of the COVID-19 mRNA vaccines at some point due to waning vaccine immunity over time.

And that's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players, and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you would like checked, email us at www.chcradio.com. We'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Asthma is one of the leading causes of trips to the emergency room for children, and there is often a correlation between high-density low-income neighborhoods and more trips to the hospital for treatment and intervention. When officials at Boston Children's Hospital noticed a spike in asthma outbreaks in certain neighborhood clusters, they decided to do something about it. They launched the Community Asthma Initiative. They realized that if you could treat the environments in the patient's home that might reduce the need to treat the patient in the emergency room.

Dr. Elizabeth Wood: The home-visiting efforts work with children and families that have been identified through their hospitalizations and emergency room visits as an identification of having poorly-controlled asthma, and also it's a teachable moment.

Mark Masselli: Dr. Elizabeth Wood heads the program, and says the first step is to identify the frequent flyers, those kids who make repeated trips to the emergency room. Then they match with the community health worker who visits their homes several times and assesses the home for asthma triggers.

Dr. Elizabeth Wood: And they work on three areas: understanding asthma itself, understanding the medications and the need for control medications, and then working on the environmental issues.

Mark Masselli: Families were given everything from HEPA filter vacuum cleaners to air purifiers, and the homes are monitored for the presence of pest or rodents. The result says Dr. Woods has been pretty dramatic.

Dr. Elizabeth Wood: What's remarkable is that there was a 56% reduction in patients with any emergency department visits, and 80% reduction in patients with any hospitalization.

Mark Masselli: The program has been so successful it's being deployed in other hospital communities around the country. The Community Asthma Initiative, a simple reshifting of resources, aimed at removing the cause of disease outbreaks in the community, leading to healthier patient populations, now that's a bright idea.

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Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and health.

Marianne O'Hare: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please e-mail us at chcradio@chc1.com, or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.