Meeting of the Advisory Panel on Outreach and Education (APOE)
Centers for Medicare & Medicaid Services (CMS)

The Liaison Capitol Hill Hotel
415 New Jersey Avenue, N.W.
Washington, D.C. 20001
December 18, 2012

EXECUTIVE SUMMARY

Open Meeting
Jennifer Kordonski, Designated Federal Official (DFO), Office of Communications (OC), CMS

Ms. Kordonski welcomed all participants. She requested that any lobbyists in attendance identify themselves, as required by law.

Welcome
Sandy Markwood, APOE Co-Chair

Members introduced themselves and their organizations.

Introduction and Overview of the Office of Minority Health
Cara James, Ph.D., Director, Office of Minority Health, CMS

Dr. James's presentation focused on CMS' Office of Minority Health (OMH). She also spoke about health disparities and social determinants of health.

Health disparities go beyond racial and ethnic disparities. They also involve gender, socioeconomic, disability, sexual orientation, and geographic disparities. The World Health Organization has developed a list of social determinants of health that includes social gradient, early life, social exclusion, work, unemployment, social support, addiction, food, stress, environment/community, and transportation. Dr. James said that health insurance, English proficiency, and health literacy can also be considered social determinants of health.

OMH was created as a result of the Affordable Care Act (ACA). Other agencies, such as the FDA, CDC, and SAMHSA have also created Offices of Minority Health. OMH coordinates minority health initiatives within CMS and also serves as a liaison between CMS, the Health and Human Services (HHS) Office of Minority Health, and offices of minority health at other agencies. OMH participates in the development of CMS policies, regulations, plans, and programs to ensure that minority health interests are represented. It also serves as a resource to other CMS components.

The work carried out by OMH is important because 6 out of 10 uninsured individuals are people of color. Also, when looking at those below 138 percent of the federal poverty level, 6 out of 10 are people of color. In addition, it is projected that Medicaid eligibility will increase in Black, Hispanic, and American Indian/Alaska Native populations as a result of the ACA. The ACA also has provisions for the Indian Health Care Improvement Act and thus will impact that particular population.

OMH is involved in priorities for the agency that include hospital re-admissions; electronic health records; and initiatives such as Million Hearts, which aims to reduce the number of heart attack and stroke victims by one million over the course of 5 years.

OMH will also be involved in efforts related to the implementation of Section 4302 of the ACA. The Section has developed data standards for race, ethnicity, sex, primary language, disability status, and other potential categories. OMH is involved in departmental efforts as well; its staff serves on the HHS Disparities Council, the HHS Data Council, and the Federal Interagency Health Equity Team.

OMH is also part of the HHS Action Plan to Reduce Racial and Ethnic Health Disparities. OMH continues to build bridges with other important partners and is currently working on the development of an OMH Communications Plan. This plan will help others to better understand OMH's role, its efforts, and other aspects related to OMH.

Recap of August 2, 2012 APOE Meeting
Sandy Markwood, APOE Co-Chair

Ms. Markwood provided a recap of the August 2, 2012, meeting. At that meeting, the panel heard from Pamela Gentry, Director of the Strategic Marketing Group at the Office of Communications, who spoke about the marketing and communication efforts surrounding the open enrollment program and initiatives related to fraud abuse.

The panel also heard from key staff at CMS who provided presentations on priority activities, including the Small Business Health Options Program (SHOP) and Web and Call Center Tools for the Health Insurance Marketplace (Exchanges).

Ms. Markwood reviewed some of the panel's recommendations from the August meeting. For the Small Business Health Options Program, recommendations included ensuring that there is a "no wrong door" approach for employers, employees, navigators, and brokers when they search for information related to SHOP. The group also agreed it would be helpful to broaden the definition of small businesses to encompass eligible nonprofits. For employers, recommendations included providing an employer screening tool, creating tools and educational resources that streamline the health plan administration process, and developing educational outreach campaigns for employers and their trusted advisors. For employees, recommendations included developing user-friendly education and marketing materials geared towards small business and nonprofit employees; and remaining aware and responding appropriately to cultural, ethnic, and demographic differences when creating and targeting messaging. For brokers, recommendations included providing transparency for all parties in transactions with the SHOPs, including broker compensation.

Recommendations for the Web and call centers included: (1) developing a plan to engage specific stakeholders to provide comments and feedback on their user experience in a test environment, (2) building awareness of the Federally Facilitated Exchanges (FFEs) and state-based Exchanges by targeting community organizations that can provide education and support tools at the grassroots level, (3) minimizing confusion among consumers with other programs (e.g., Medicaid, CHIP, etc.), (4) developing protocols to handle consumer complaints, and (5)

ensuring that information flowing into the customer support centers is updated in real time to accurately address customers' questions and complaints.

CMS Response to APOE Recommendations from August 2, 2012 APOE Meeting
Julie Green Bataille, Director, OC, CMS

Ms. Bataille explained that CMS values the work, input, and recommendations provided by APOE. She added that information supplied by the panel has been useful and timely.

With respect to SHOP, CMS is planning to develop a transparent marketplace for employers of small businesses to have access to in-depth information regarding health plan options. CMS will also develop educational online content for individuals, as well as a variety of partner tools to be used for in-person conversations and consumer support. The information will be helpful for small businesses, their employees, and others.

The plan is to integrate SHOP fully into the CMS Web site currently being built, rather than having it be a stand-alone piece. Consumers will be able to self-identify based on who they are coming into the site. CMS is also planning to develop user-friendly education and marketing materials geared towards small businesses and nonprofit employers to ensure they understand the value and options available to them. CMS recognizes the importance of including nonprofits in the definition of small business and believes they are important in educating others about SHOP.

CMS is working closely across all federal agency partners to understand how it can best leverage existing programs and resources. For SHOP, in particular, the Small Business Administration has been an enormously valuable and collaborative partner. Discussions are underway about a series of educational steps that will begin next year.

CMS is planning to provide transparency for all parties in transactions related to SHOP, including how brokers will be compensated. CMS wants to develop a clear set of guidelines on how employees are helped throughout the process by brokers, as well as any expectations placed upon brokers when working with SHOP. CMS is currently working on these guidelines and anticipates that information provided to brokers will include clear expectations on their role in assisting employers and employees throughout the process. State licensing requirements will apply to brokers participating in all SHOPs, including existing compensation transparency guidelines.

With respect to the Web and call center operations that will support the FFEs, CMS is building a Web site to support the new health insurance marketplace. The site will serve as a single destination for individuals to understand – in plain language – their eligibility determination and to compare plans and enroll, all in one place. Educational content specifically geared for consumers is expected to be available early next year. CMS is conducting research to ensure that the content, tools, and messaging resonate across all of the audiences being served.

Research is also underway to better understand attitudes and barriers towards health insurance, as well as where uninsured individuals reside. CMS has analyzed the uninsured population across the country and divided it into different behavioral segments. There has been cross-referencing with census data to geo-target where individual pockets of populations reside. States and other

stakeholders have also asked to cross-reference this information with commercially available marketing databases. This information will be available on the CMS Web site.

CMS is building awareness about the emerging marketplace by working with a variety of organizations, including libraries, religious institutions, academic institutions, elementary schools, provider organizations, and others. CMS is also engaging national, state, and local organizations– many of which are already carrying out similar work – to identify networks and pipelines that can relay information to people who stand to benefit.

Federal partners are also being involved in these efforts. As was done with launching Medicare Part D and the CHIP program, federal partners are an enormous opportunity to leverage resources. This approach involves using existing distribution channels and in-person networks to distribute information and also serve as resources for individuals.

CMS is committed to ensuring a customer service approach that allows customers to request and receive information across a variety of channels. The customer service experience will provide an integrated approach by supporting consumers in the method they prefer. CMS already has experience in this area and brings existing mature business processes across its customer service channels to ensure continuous updates, based on feedback and information obtained from consumers.

Individuals will have questions, so it is important to have a process and mechanism in place to quickly ascertain the question, obtain the needed information, and relay the information to the individual serving the consumer. This functionality is being planned while building the call center.

Tools will also be integrated so that information from the Web site will be available to customer service representatives who will be able to interface with consumers through mechanisms such as Web chat – a system similar to one currently being used to serve Medicare beneficiaries.

Privacy, security, and confidentiality of information are important. CMS is making sure that, as individuals go through the process of the actual application, they will understand why the information is needed, what will or will not be done with the information, and how it will benefit the individual at the end of the process.

Whether individuals seek assistance in person, online, or over the phone, they will obtain the same answer and will have access to information in multiple ways. There will be a continuous feedback mechanism to ensure that CMS has the most up-to-date information possible to serve consumers.

Listening Session with CMS Leadership
Patrick Conway, M.D., M.Sc., Director, Center for Clinical Standards and Quality and Chief Medical Officer, CMS

Dr. Conway described the size and scope of CMS's responsibilities. CMS has three main aims: better care for individuals, better health for the population, and lower cost through improvement.

CMS is the largest purchaser of health care in the world. Medicare and Medicaid pay for approximately one-third of all national health expenditures. CMS programs provide health care coverage for roughly one out of every three Americans (about 105 million beneficiaries). Every day the Medicare program pays out more than $1.5 billion in benefit payments, and CMS answers approximately 75 million inquiries per year.

The Center for Clinical Standards and Quality employs more than 425 federal FTEs and approximately 10,000 contractors who are focused on improving quality across the nation. CMS is also involved in quality improvement, quality measurement, public reporting, incentive programs, regulations, and coverage decisions. For example, wherever possible, efforts have led to removing outdated, unnecessary regulation that is often replaced with patient-centered regulation. CMS is also involved in survey and certification work, as well as in making coverage decisions for Part A and B services.

Dr. Conway briefly mentioned a recent article he published in *JAMA*, entitled *Engaging Physicians and Leveraging Professionalism: A Key to Success for Quality Measurement and Improvement.* He explained that physician and other clinician engagement is essential to the success of quality measurement and improvement efforts. Education and outreach are also key.

Dr. Conway briefly reviewed the priorities of the National Strategy for Quality Improvement in Health Care. He also discussed the CMS framework for quality improvement.

Engaging Patients in the Health Care Quality Initiative
Jean Moody Williams, R.N., M.P.P., Center for Clinical Standards and Quality, CMS

Ms. Williams's presentation focused on engaging patients in health care quality.

CMS has a quality strategy based on the HHS National Quality Strategy. The foundational principles of the CMS quality strategy are to: eliminate disparities, strengthen infrastructure and data systems, enable local innovations, and foster learning organizations. Ms. Williams reviewed the six goals of the CMS quality strategy.

The CMS quality strategy impacts four areas: Quality Improvement Organizations (QIOs), End-Stage Renal Disease (ESRD) Networks, Payment Programs Rewarding Patient Experience, and Other Projects, such as innovation.

CMS engages QIOs to perform at a grassroots level in all 50 states, DC, the U.S. Virgin Islands, and Puerto Rico. QIOs are change agents and conveners for widespread, significant improvements in health care quality. They offer knowledge and resources for improving health quality, efficiency, and value that can benefit all patients, residents, and clients. QIOs base their work on clinical evidence and generate extensive, reliable data about clinical performance. They also serve as independent, objective, and collaborative partners. QIOs focus on safer care, patient-centered care, coordinated/integrated care, and improved health for patients and communities.

Through the Patient & Family Engagement Campaign, each QIO will create a tailored initiative to meet needs in their local area and focus on: preventing avoidable re-admissions, preventing falls, improving cardiac health, and caring for individuals diagnosed with dementia. Within

these clinical foci, the QIOs will seek to reduce health care disparities, increase use of preventive services, and improve access to care.

Ms. Williams explained that ESRD networks have three main aims: better health for patients with ESRD, lower costs of dialysis care through improvement, and better care through patient and family centeredness. CMS engages the ESRD networks to work in 18 jurisdictions across the country. They serve as patient care navigators for more than half a million patients with end-stage renal disease who are treated in nearly 6,000 dialysis clinics, as well as those waiting for and recovering from a kidney transplant. These networks achieve and measure changes at the patient level by collecting data, analyzing it to inform improvement, and monitoring those improvements for substantive impact.

Discussion of Recommendations
APOE Members

Following the above presentations, the panel provided a series of recommendations.

For the Office of Minority Health, several recommendations were offered in four broad areas: (1) having the office focus on equity as a whole, (2) developing a segmented communications strategy, (3) leveraging 2014 opportunities (e.g., benchmarking, data collection), and (4) developing specific performance standards (e.g., access to care, quality outcomes).

Other recommendations included: (1) making enhancements to assist CMS quality strategies, (2) developing a report card mechanism, (3) increasing partnerships aimed at increasing engagement and quality of care, (4) continued use of health information technology for specific purposes (e.g., improved quality of care, matching patients to data), and (5) supporting engagement of patients and caregivers.

Public Comment
Sandy Markwood, APOE Co-Chair

No public comments were offered.

Adjournment
Jennifer Kordonski, DFO, CMS

Ms. Kordonski thanked all panelists and speakers for their participation. Before adjourning, she informed participants that the date for the next meeting is not yet set, but will likely take place in March. The exact date and other details will be forthcoming.