

EXECUTIVE SUMMARY

In-Person Meeting of the Advisory Panel on Outreach and Education (APOE)

SEPTEMBER 21, 2023, 8:30 a.m.–4:00 p.m. ET

Open Meeting

Lisa Carr, Designated Federal Official (DFO), Senior Advisor, CMS Partner Relations Group (PRG), Office of Communications (OC)

Ms. Carr opened the meeting and called the meeting to order at 9:00 a.m. She introduced herself as the DFO and reviewed housekeeping items to ensure compliance with the Federal Advisory Committee Act (FACA). She announced that for all the comments to be captured, everyone must speak clearly into the microphones before them; any individuals experiencing issues with their devices should let Kelley Vinton from Novak Birch and her colleague know.

Ms. Carr explained that APOE will hear public comments at the end of the meeting; any individual wishing to give public comment must sign up at the registration desk; the time is set aside for comments only. Specific questions should be provided to her, and she'll follow up with an answer. In compliance with a White House directive, she asked that lobbyists identify themselves as such before speaking.

Ms. Carr stated that everyone is required to have an escort throughout the federal government building hallways. They must display a badge at all times and should connect with available CMS staff when they would like to be escorted outside of the room. She then turned over the meeting to Stefanie Costello, CMS PRG Director, for her opening comments.

Welcome & Opening Comments

Stefanie Costello, Director, PRG, OC, CMS

Ms. Costello thanked the APOE members for joining the meeting and previewed the agenda for the meeting, reminding attendees they would hear four presentations: the CMS Health Equity Conference, Findings from Initial Race and Ethnicity Data Collection on the Medicare Part C/D Enrollment, the Behavioral Health and Telehealth Learning Collaborative, and the National Strategy for Family Caregivers. She introduced Neil Meltzer as the APOE Chair and Carrie Rogers as the APOE Vice-Chair and turned the meeting over to Mr. Meltzer.

Opening Comments and Panel Introductions

Neil Meltzer, APOE Chair

Mr. Meltzer welcomed attendees and reminded them that this is an open meeting and everything said is on the record. He reminded them this is a federal committee, a federal task force or panel, and if they wish to send any kind of a notification about their involvement on it, they must clear it through CMS first. He stated that the opinions expressed by panel members are their individual opinions and do not necessarily reflect the views of the organizations with which they are affiliated.

Mr. Meltzer then introduced new panel members and asked all the panel members to introduce themselves. After all of the introductions, he turned the meeting over to Ms. Costello.

Certificate of Appreciation for Departing Panel Member

Stefanie Costello, Director, PRG, OC, CMS

Ms. Costello thanked Jina Ragland for her service as an APOE member; her term expires in November 2023. A certificate of appreciation was presented to Ms. Ragland and a photo was taken.

Swearing-In of New APOE Members

Lisa Carr, DFO, Senior Advisor, PRG, OC, CMS

Ms. Carr introduced and swore in four new APOE members: Paula Campbell, Marsha Schofield, Tricia Sandiego, and Andrea Haynes. Each stood, raised their right hand, and read the Oath of Office, Affidavit as to Striking Against the Federal Government, and the Affidavit as to the Purchase and Sale of Office with Ms. Carr. Lynn Kimball, a fifth new APOE member, was unable to attend the meeting.

CMS Response to APOE Recommendations from the June 22, 2023, Meeting

Stefanie Costello, Director, PRG, OC, CMS

Ms. Costello informed the APOE members they would find CMS's response to APOE's recommendations from the June 22, 2023, meeting in the meeting packet. The APOE members did not have any questions. Ms. Costello turned the meeting back to Mr. Meltzer.

The CMS Health Equity Conference

Ashley Peddicord-Austin, MPH, Health Communications Specialist, Office of Minority Health (OMH), CMS

Mr. Meltzer introduced the speaker and mentioned that her bio was in the meeting packet. Ms. Peddicord-Austin then began the presentation.

OMH seeks regular feedback in the planning of major events, including the CMS Health Equity Conference that took place on June 7–8, 2023, at Howard University in Washington, DC. OMH used this opportunity with the panel to debrief on the 2023 conference’s successes and shortcomings and compile feedback to plan the 2024 conference.

This inaugural conference assembled leaders in health equity from federal agencies, health provider organizations, and others, in person and virtually. Participants heard from CMS’s leadership regarding developments and updates, learned about current research on health equity, discussed practices and solutions, and collaborated on community engagement efforts.

When the dates and venue were confirmed, invitations were sent to speakers and moderators. OMH scheduled listening sessions with partners and issued a Call for Proposals and received over 400 submissions. These proposals helped determine the sessions and panels offered.

Registration was free, and 5,600 people registered: 2,900 virtual and 506 in person. Sixty-six percent of attendees attended most of Day 1, and 58% for most or all of Day 2. All social media posts were positive or neutral. National and local news outlets, such as Healthcare Dive, Politico, and Morningstar, highlighted the speakers and reinforced CMS as a leader in advancing health equity.

There were 600 responses to the OMH post-conference survey: 97% of respondents agreed the conference energized and renewed the will for action and change. The emphasis on health equity bolstered recognition of CMS as a leading advocate and increased their understanding of CMS’s core values around advancing health equity. Suggestions included making the virtual portion more accessible for vision-impaired participants—this was implemented on the second day—and including speakers with more diverse and lived experiences.

After the presentation, Mr. Meltzer opened the floor for general questions and comments about the content of the presentation. Ms. Peddicord-Austin then asked for feedback for the 2024 conference and presented the following questions.

1. Are there any reactions to the proposed themes for the conference?
 - a. **Actionable** items to make progress to health equity,
 - b. **Sustaining** an interest in health equity for the long term, and
 - c. **Health equity** as part of full equity/Social Determinants of Health (SDOH)
2. How can CMS OMH continue to involve partner voices in the conference?
3. How can we involve lived experience and voices of patients, caregivers, and those seeking coverage in the conference?
4. Additional considerations appreciated.

Mr. Meltzer then opened the discussion to the panel.

Discussion of Recommendations among APOE members and Ms. Peddicord-Austin

The panel made a series of preliminary recommendations in these key areas:

Thoughts and suggestions toward the proposed themes for the 2024 conference: Actionable, Sustainable, and SDOH:

Actionable and Sustainable:

Actionable is sustainable—the two often go hand in hand—it is important to focus on both. Certain individuals and communities might not view actionable as sustainable based on prior experiences. There needs to be more thought towards keeping communities involved. Advocates are looking for a way to take what they learn and translate it to their work. Include a section dedicated to actions and actionable solutions so participants are not left feeling “now what?” What steps, for example, can health care organizations, Federally Qualified Health Centers (FQHCs), community-based organizations take, that incorporate equity into what they're doing? Focus on lessons learned—lived experiences will help bring both the actionable and sustainable themes to life. Conduct long-term follow-up with attendees. Create a LinkedIn buzz with periodic placements through the year. Key learnings or key results takeaway document.

Health Equity (SDOH):

How can health equity not just be a buzzword? How do we make sure the people doing the work feel supported and can do it for the long term? In economic development, education leads to health equity. Offer virtual workshops between conferences that address conference themes prior to the event for continuous educational opportunities.

Ways OMH can continue to involve partner voices and include lived experiences and voices of patients, caregivers, and those seeking coverage: Continue to tell compelling stories with patients and caregivers’ side-by-side. Include sessions on things that people have done, lived experiences and how CMS addresses them or other strategies that people can use to address health equity. Diversity was a large point of the discussion—while the panels and the speakers for the 2023 conference had different backgrounds, there could have been more diversity. Diversity means more than race and ethnicity—it includes experiences and background. Include partners and speakers with different voices and experiences in health care. Require future proposals to include lived experiences. Conduct a gap analysis to see who may be missing. Consider stories from those who have stopped seeking coverage after bad experience or who feel the system no longer serves them. Involve non-traditional organizations like the National Association of Social Workers (NASW) or National Association of Community Health Workers (NACHW) for more community voices. Video presentations for patients that can't travel. Require presentations to include someone who has experienced the topic or address the lived experience in the proposal. Include partners in the proposal review process.

Additional considerations: Focus on speaker quality versus quantity. The conference felt saturated. Increasing breaks between sessions from 15 to 30 minutes might allow participants to decompress and appropriately engage in discussions and networking. This might increase the

conference to three days. Invite and engage the press throughout the entire conference. Make sure they do not focus only on keynote speakers. Include highlights and takeaways from everyone's table in one post that can be shared on social media post-conference. There were 45 tables in the Gallery—participants could not visit them all. Hold it in other regions, to account for significant regional differences. Offer tracks—for rural, urban, etc. Remove barriers for speakers; the need for speakers to attend in person could have impacted quality and diversity. Offer financial assistance to speakers or allow virtual presentations. If online participation is not an option, collect stories to share via video. Analyze why certain participants are not engaging in conferences like this. Offer CME or CEUs. Provide food and beverages throughout the conference. Shorten session timeframes—most were an hour and a half. Turn unaccepted proposals into posters. This could help address the concern about diversity.

After the discussion, Mr. Meltzer gave the panel a 15-minute break.

Findings from Initial Race and Ethnicity Data Collection on the Medicare Part C & D Enrollment

Nancy Chiles-Shaffer, MS, PhD, Data Analytics & Research Group, OMH, CMS

After the break, Mr. Meltzer introduced the next speaker, told attendees they would find her bio in the packet, and asked her to start her presentation.

Dr. Chiles-Shaffer stated that OMH strives for accurate, complete data collection. While race and ethnicity elements are not required for Medicare Part C/D enrollment, accurate and complete data help CMS create evidence-based policies and regulations, assess the alignment of these policies and regulations, and aligns the needs of the communities and individuals CMS serves.

CMS's limited authority to collect all elements directly, contributes to incomplete data and prevents fully data-driven decisions. Efforts to address these health equity-related data issues are underway and being prioritized—increasing collection and using standardized data to improve health care for rural, tribal, and geographically isolated communities is a top priority.

Dr. Chiles-Shaffer described the Office of Management and Budget's (OMB) approval for the 2023 Open Enrollment form and the impact of the approval on data collection. OMB approved the revised information collection on July 1, 2022, to include race and ethnicity questions on the Medicare Part C/D enrollment form. Data collection occurred between January 1, 2023, and March 31, 2023. This granular information helps CMS understand the diversity of the beneficiary population. As part of the conditional approval, CMS must complete a study of participants who did not respond to the race and ethnicity questions. CMS was given approval to complete 120 interviews with non-respondents who used the new enrollment form during the 2023 Medicare Advantage (MA) Open Enrollment Period and the 2024 Annual Election Period.

The interviews would help CMS understand why people did not respond to the new race and ethnicity questions, how they perceived the questions, and identify the drivers behind their

decision. CMS would use this information to improve the questions and the form. Interviews were separated by plan type: MA-only enrollees, MA-Prescription Drug enrollees, and Medicare Prescription Drug Plan enrollees. Ninety-three interviews were completed with MA Open Enrollment Period enrollees—90 of the 93 interviews were included in the analysis.

Most had no issue providing race and ethnicity data and would have answered the questions, but almost two-thirds did not recall seeing the questions—some may not have seen them if an insurance broker or a family member filled out the form. Understanding was also an issue—most understood the term “race” and the response options but may not have understood the term “ethnicity.” This suggests further assistance is needed to avoid confusion. Assistance could include instructions for answering the questions and adding the purpose of the questions.

After the presentation, Mr. Meltzer opened the floor for general questions and comments on the presentation. The panel then moved to discussing the questions Dr. Chiles-Shaffer shared in the presentation:

- How would you encourage people to provide this information? What messages would resonate? Where should we reach people?
- What tools do providers and staff need for this conversation?
- What barriers need to be addressed?

Discussion of Recommendations among APOE members and Dr. Chiles-Shaffer

The panel made a series of preliminary recommendations in these key areas:

Strategies to encourage participants to provide race and ethnicity information, including messaging and places to reach them: Include disclosure information, detailing the use and benefit of the information. Offer education on race and ethnicity questions from trusted sources where participants gather. Print the information in different languages to help non-English speakers. In some languages, race and ethnicity are presented as the same. Educate State Health Insurance Assistance Programs (SHIP) counselors and navigators where these forms are generally completed or create focused training. Partner with senior centers. There might be concerns with individuals not wanting to reveal their immigration status; tailor forms and education so that people do not feel threatened. Inform individuals that these questions do not have anything to do with eligibility; they are designed to help understand service gaps.

Tools providers and staff need for this conversation: Frequently asked questions website. Public relations program or an educational campaign to help people of all ages understand why this is important. Utilize social media to appeal to all age groups.

Different barriers and the strategies and/or tools needed to overcome them: Statutory barrier would be the largest to overcome—explain there is no authority to require this information and providing it has no bearing on enrollment. Create a document for providers to talk about the statutory barrier with patients including how providing this information will not impact eligibility.

Those who are educating should be trusted members of the community with the language skills and the cultural nuances to explain why this information is important, and that, for instance, it wouldn't negatively impact immigration status—that tends to be a concern for a lot of immigrant populations.

After the discussion, Mr. Meltzer released the group for lunch.

Behavioral Health & Telehealth Learning Collaborative

Commander Nathan Caulk, MS, RN, NHDP-BC, Senior Nurse Officer, Marketplace Plan Management Group; Center for Consumer Information & Insurance Oversight (CCIIO), CMS

Mr. Meltzer introduced the speaker and asked him to start his presentation.

Commander Caulk provided background on the Learning Collaborative. On March 1, 2022, the White House announced that as part of the Unity Agenda, HHS would create a Learning Collaborative in partnership with state Departments of Insurance (DOI) to deliver tele-behavioral health services across state lines. CCIIO engaged state DOI officials from seven states—Montana, New Mexico, Oklahoma, Pennsylvania, South Carolina, Texas, and Washington—to identify paths for greater adoption of tele-behavioral health for privately insured consumers. CCIIO also connected with other CMS and HHS components, including the CMS Behavioral Health Steering Committee, Health Resources & Services Administration, Office of the Assistant Secretary for Planning and Evaluation, Substance Abuse and Mental Health Services Administration (SAMHSA), and external partners from the National Association of Insurance Commissioners (NAIC).

CCIIO quickly realized that each of the seven states was at a different point of telehealth usage and access. CCIIO facilitated state-to-state sharing of best practices and troubleshooting, holding three sessions (October 2022 through February 2023), and developing an interview guide. Each state DOI provided valuable examples of challenges and successes. The final session included a presentation on one state's recently passed and implemented telehealth parity act.

Commander Caulk shared some key findings from the final report and a list of relevant resources. Findings included examples of challenges and successes across the seven states, the impact of shortages in the behavioral health provider workforce, payment parity, interstate practice and licensure reciprocity, broadband access, and novel coverage models. CCIIO encouraged other states to leverage information and resources from the report, to overcome their own tele-behavioral health access gaps.

After the presentation, Mr. Meltzer opened the floor for general questions and comments before addressing the presentation questions.

Mr. Meltzer reminded the panel that they had received the discussion questions, which were in the presentation, and he opened the discussion.

1. What additional resources or information about tele-behavioral health care access in the individual market does the panel suggest as pertinent that was not captured in the Learning Collaborative Final Report?
2. We recognize the complexities of expanding coverage for tele-behavioral health services and understand that policy initiatives in this space require the engagement of a broad set of stakeholders to overcome multifaceted barriers. The Learning Collaborative is one example of a partnership that has made strides in the tele-behavioral health landscape. What does the panel believe is an optimal strategy for addressing the barriers that were noted in the Learning Collaborative Final Report?
3. Based on the Key Findings in the Learning Collaborative Final Report, how does the panel suggest to best communicate this information to privately insured consumers accessing behavioral health services? For example, the most frequently cited barrier to increasing access for behavioral health services was the national shortage of behavioral health providers. What does the panel recommend as a strategy for communicating this barrier to consumers who are seeing coverage gaps in behavioral health services?

Discussion of Recommendations among APOE members and Commander Caulk

The panel made a series of preliminary recommendations in these key areas:

Additional, pertinent resources/information about tele-behavioral health care access in the individual market not captured in the Learning Collaborative Final Report: Broadband access and whether health insurance can help low-income communities gain access to broadband. Partner with state DOI trying to increase telehealth use in their state—encourage them to communicate to their communities about accessing a federal program that offers discounted internet. Broader reciprocity across state lines. Providers are discriminating against those with Marketplace coverage due to the complexity of the payment codes and reimbursement.

Strategies for addressing the barriers noted in the Learning Collaborative Final Report: Menu of available options. Parity, simplicity in options and common definitions of telehealth. Convincing practitioners to accept insurance and Medicare/Medicaid is a barrier due to perceived complexity. Some practitioners are giving up their offices because telehealth is cheaper—this could create “care deserts.” Patients are unaware of options and programs that would provide access to telehealth. Encourage state DOI to share these options with the public. Ensure continuity of care—case management and follow-up appointment management need to accompany virtual services. Consider allowing individuals completing clinical hours to provide tele-behavioral health. Knowing how to navigate the infrastructure pre- versus post-pandemic is a barrier. How do we gain trust that we’ll keep patient data safe, when companies working in telehealth have been selling patient information? Create a cheat sheet for providers outlining how and what to bill.

Communicating regarding barriers to privately insured consumers who are seeing coverage gaps in behavioral health services: Promote group telehealth therapy coverage—this creates more work for the provider. Provide lessons learned. Cost of care and lack of awareness of programs leads to fear and embarrassment. Reimbursement can be difficult to figure out, but it makes health care more affordable. Get information to the public through different platforms, educate them on finding the programs and enrolling. Offer cost options—consider pre-deductible visits. Share data and information on in-person care versus telehealth and the differences and pros and cons of both. Use pre-existing communication channels for patient groups to reach patients and distribute information. Partner with unconventional organizations and coalitions like America’s Health Insurance Plans (AHIP), NAIC, and One Mind. Advertise solutions to the consumer. Address the challenges for health care providers trying to contract with insurers and patients when they do not have a physical location in the state.

After completing the discussion, Mr. Meltzer gave the panel a 10-minute break.

National Strategy for Family Caregivers

Kathleen Otte, Regional Administrator, Office of Program Operations and Local Engagement (OPOLE), CMS

After the break, Mr. Meltzer introduced the next speaker.

Ms. Otte shared stories from her work with assistance homes—while data is important for decision-making, real stories impact real people. Many programs are designed to support caregivers, but not everyone knows about them. Most caregivers are overwhelmed and stressed—they often balance full-time care with a full-time job, which does not leave time to research available services. It is difficult to identify caregivers—most health offices rely on caregivers to self-report, and many choose to not identify.

The Office of Program Operations and Local Engagement (OPOLE) is the regional point of contact for its counterparts in CMS, implementing the agency’s local outreach strategy and messaging. OPOLE leads state, community, and organizational efforts to bring awareness to CMS programs benefiting family caregivers and family members. The Administration for Community Living (ACL) will likely be a key partner in OPOLE’s planned actions—they are uniquely fit to collaborate on caregiving. The main goal is to use existing resources and programs without replicating them.

Ms. Otte provided an overview of OPOLE’s approach, currently focused on involving regional stakeholders and developing outreach materials. She proposed a phased approach to ensure OPOLE meets its high-level deliverables and emphasized the importance of outreach to ensure caregivers are aware of resources.

After the presentation, Mr. Meltzer opened the floor for general questions and comments on the content of the presentation. Mr. Meltzer moved the panel to discuss the following questions, which were also in the presentation:

1. Beyond those groups already mentioned, who should OPOLE be further engaging with to better understand how CMS can best support family caregivers?
2. Who are the first-line and second-line audiences/people on the ground that OPOLE needs to target for this information and materials?
3. What information gaps exist for helping these populations?

Discussion of Recommendations among APOE members and Ms. Otte

The panel made a series of preliminary recommendations in these key areas:

Parties that OPOLE should further engage to better understand how CMS can best support and identify family caregivers: Reach caregivers through the person they are caring for. Do providers know how to identify caregiver burnout and available programs? Schools and childcare providers, including school nurses and counselors. Barbershops and beauty salons. Pharmacies. Support groups. The YMCA. Respite programs. Nursing facilities. Health centers utilizing Programs of All-Inclusive Care for the Elderly (PACE) to identify eligible people.

First-line and second-line audiences/people on the ground that OPOLE needs to target for this information and materials: United Way. Aging and Disability Resource Centers. PACE. Diversity, Equity & Inclusion (DE&I) programs. SHIPs. Companies with transportation options. Childcare providers. Faith-based organizations. Certified community behavioral health clinics (CCBHCs). SAMHSA. Medicare Rights Center. Community mental health centers. School-based health centers. Home health services. Insurance companies. SAGE—Advocacy & Services for LGBTQ+ Elders. Barbershops and beauty salons. American Cancer Society (ACS), American Heart Association (AHA), American Diabetes Association (ADA), and Alzheimer’s Association.

Information gaps that exist in helping these populations: Behavioral health coaching—some might not use their vouchers and resources even after learning about them. Family structure and culture—the person being cared for might still hold power in the household. Health care coverage information can be tricky to find and digest. Ensuring providers receiving funding from CMS can identify caregivers and have the information to share. Elder care support in the workplace. Disparities around different types of people, particularly in age. Caregiving is associated with being an “older person” issue, but younger caregivers are stepping into that role. Contact the children caring for their grandparents. Kids are now completing forms for their grandparents.

After completing the discussion, Mr. Meltzer opened the floor for public comment.

Public Comment

Neil Meltzer, APOE Chair

No individuals signed up to provide public comment during this meeting.

Final Comment

Neil Meltzer, APOE Chair

Mr. Meltzer stated that the next APOE meeting will be virtual and is scheduled for February 1, 2024. The next in-person meeting will be on April 18, 2024. He then turned the meeting back to Ms. Carr.

Adjourn

Lisa Carr, DFO Senior Advisor, PRG, OC, CMS

Ms. Carr adjourned the meeting at 3:30 p.m. (EDT) and noted that the next meeting of APOE will be announced in the Federal Register.