**Meeting of the Advisory Panel on Outreach and Education (APOE)**

**Centers for Medicare & Medicaid Services (CMS)**

**The Hubert H. Humphrey Building**

**200 Independence Avenue, SW**

**Washington, DC 20201**

***November 14, 2019***

**EXECUTIVE SUMMARY**

**Open Meeting**

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

Ms. Carr called the meeting to order at 8:30 a.m. She welcomed all participants and served as the Designated Federal Official (DFO) to ensure compliance with the Federal Advisory Committee Act (FACA). Ms. Carr asked any lobbyists in attendance to please identify themselves as such prior to speaking. She then turned over the meeting to the APOE Chair, Louise Knight.

**Welcome and Introductions**

***Louise Knight****, APOE Chair*

Ms. Knight welcomed all panel members. Panel members and speakers then introduced themselves.

Swearing In of New APOE Members

*Susie Butler, Director, Partner Relations Group, OC, CMS*

Ms. Butler conducted a group swearing in for all new members. Members read in unison the “Oath of Office.” The new panel members sworn in were Dr. Nazleen Bharmal, Mr. Ted Henson, Dr. Joan Ilardo, Dr. Cori McMahon, Mr. Alan Meade, and Mr. Morgan Reed.

Ms. Butler welcomed all new members to the panel. She invited the group to reach out to her if anyone was interested in the vacant Co-Chair position.

Certificates to APOE Members who are Departing

*Louise Knight, APOE Chair*

On behalf of CMS, Ms. Knight provided a certificate of appreciation to Cathy Phan, as it was her last meeting.

**Recap of July 16, 2019 Meeting and CMS Response to APOE**

***Louise Knight****, APOE Chair*

*Susie Butler, Director, Partner Relations Group, OC, CMS*

Participants were informed that the executive summary of the July 16, 2019 meeting could be found in their packets. Their packets also included CMS responses to the panel’s recommendations from the April 10 and July 16, 2019 meetings. They were encouraged to read the materials at their leisure.

CMS’ Actions to Address the Opioid Epidemic

*Anna Bonelli, Senior Policy Advisor to the Principal Deputy for Operations and Policy, Office of the Administrator, CMS*

An estimated 11.4 million people misused prescription opioids, putting them at risk for dependence and addiction. In addition, more than 2 million people suffer from opioid use disorder. Treatments exists to address opioid use disorder, including medication-assisted treatment (MAT), but only 20 percent of people with opioid use disorder receive treatment.

As one of the largest payers of health care services, CMS has a key role in addressing the opioid epidemic. CMS is focused on three areas: 1) managing pain using a safe and effective range of treatment options that rely less on prescription opioids (prevention), 2) expanding access to treatment for opioid use disorder (treatment), and 3) using data to target prevention and treatment efforts and to identify fraud and abuse (data).

In the area of prevention, CMS is establishing a framework that allows Medicare Part D plans to implement drug management programs. Under such programs, a plan can limit access to coverage for frequently abused drugs (e.g., opioids and benzodiazepine) for those identified as at risk beginning with the 2019 plan year. This effort will exclude beneficiaries who have cancer, receive palliative care, or are in hospice or long-term care. In addition, as of January 1, 2019, Medicare drug plans will perform additional safety checks on opioid prescriptions, and may send the pharmacy an alert for review before a prescription is filled.

CMS prevention efforts are also carried out in partnership with states. State Medicaid agencies are required to report annually to CMS their drug utilization review program activities and processes to ensure appropriate drug utilization, including appropriate opioid utilization. This can include placing quantity limits on opioids, monitoring the concurrent use of opioids and benzodiazepines, employing Prescription Drug Monitoring Program requirements, and using tools that measure morphine milligram equivalents per day.

Medication-assisted treatment, including opioid treatment programs (OTPs), combines behavioral therapy and medications to treat substance use disorders (SUD). Medicare will cover alcohol and drug treatment services if services are from a Medicare-participating facility, and if the services are reasonable and necessary. Covered services include: psychotherapy; counseling; patient education regarding diagnosis and treatment; post-hospitalization follow-up; screening, brief intervention, and referral to treatment services; alcohol misuse screening and counseling; and screening for depression. Medicare OTP coverage will start in January 1, 2020. States also have the option of covering SUD treatment services like counseling, psychosocial, and behavioral health therapies. In addition, all marketplace plans cover essential health benefits including benefits for mental health, SUD, and prescription drugs.

In the area of data, CMS tracks prescription opioid trends and monitors the effects of CMS interventions. CMS can identify patients at risk and help target areas most in need of prevention and treatment efforts. The [Medicare Part D Opioid Drug Mapping Tool](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/OpioidMap_Medicare_PartD) gives providers, local health officials, and others the data about their community’s Medicare opioid prescription rate so they can better target prevention and treatment efforts. The tool shows geographic comparisons at the state, county, and ZIP-code levels, as well as Medicare Part D opioid prescription claims with personally identifiable information removed.

Discussion of Recommendations among APOE Members and Ms. Bonelli

Following the presentation, the panel provided a series of preliminary recommendations, including recommending alternative practices to pain management (e.g., acupuncture, physical therapy, cognitive behavioral therapy, chiropractors) in addition to medication; waiving copays for pain management alternatives; and adopting a multimodal approach for seniors that goes beyond only their opioid profile.

The panel recommended increasing the number of providers (currently only 1,200 Opioid Treatment Programs (OTPs) are SAMHSA-certified) or having this type of service integrated into primary care; preventing gaps by ensuring that Medicaid programs reimburse primary care physicians until OTPs are enrolled; considering dentists as prescribers for treatment programs; and coordinating with HRSA on provider training in this area. CMS should also consider increasing transparency on what medications are covered, simplifying prior authorization, or waiving it altogether for preferred drugs.

It was also recommended that CMS address social determinants of health (e.g., language, transportation, care management); increasing outreach, awareness, and retention in African American and Hispanic communities by engaging them through their smart phones; provide outreach where individuals live, work, play, pray, and shop; and engage other partners such as pastors, community-based organizations, caregivers, senior centers, agencies on aging, Head Start programs, the Program of All-Inclusive Care for the Elderly, school systems, employer groups, professional associations at the state level, local health departments, health systems, community health centers, county departments of public health, city/state universities, and community workers.

Other recommendations included considering demonstration projects that reduce the costs of services to the patient to reduce access barriers; piloting some approaches through Federally Qualified Health Centers, holding webinars to share strategies used by other states are (best practices); covering peer support services; providing education in treating SUDs in seniors; and

covering SUDs as a chronic disease in Chronic Care Management codes.

**Public Reporting and Hospital Star Ratings**

***Joseph Clift****, Technical Advisor, Center for Clinical Standards and Quality, CMS*

Hospital Compare was launched in July 2016. Hospital Compare provides information about the quality of care at over 4,000 Medicare-certified hospitals. Its purpose is to summarize quality measure information in a way that is useful and easy to interpret for patients and consumers (single star rating). It is meant to complement other quality information tools and individual measures.

Hospital Compare offers ratings from 1 to 5 stars, with the most common overall hospital rating being 3 stars. The hospital rating is a summary of various measures and shows how well each hospital performs, on average, compared to other U.S. hospitals. The measure groups used to calculate the overall hospital rating include mortality, safety of care, readmissions, patient experience, effectiveness of care, timeliness of care, and the efficient use of medical imaging.

CMS is currently considering changes to the Hospital Compare star rating to increase simplicity of the methodology, predictability of star ratings over time, and hospital comparability. Various approaches to changes are being considered, including regrouping some of the measure groups, changes in score calculation, K-Means clustering, risk adjustment, and peer grouping.

Currently, Latent Variable Modeling (LVM) is the statistical approach used to estimate a group score for each of the measure groups. Although not completely intuitive, the LVM method is empirically driven where measures contribute different weights. An alternative approach is the non-modeling or “explicit” approach, which would increase the simplicity of methods and the predictability of individual measure emphasis. The explicit approach has disadvantages, including the fact that different hospitals report different measures.

The K-means clustering approach could be used to group the hospital summary scores into 5 star rating categories. This approach would separate scores into 5 clusters (or star categories) such that hospital summary scores are most like other summary scores in the same category or least like summary scores in other categories. One of the advantages of this approach is that it is statistically driven based on performance, rather than using arbitrary points. A disadvantage is that cut points are not predetermined, so hospitals cannot predict star ratings in advance.

In response to stakeholder requests and to align CMS programs, CMS is also considering accounting for social risk factors in the readmission measure group. Risk adjustment could take place at the group level or star level. Also being considered is peer grouping for overall star rating. Peer grouping could be helpful because hospitals report different amounts and types of measures. These differences reflect differences in patient case mix and services among hospitals.

All these modifications are currently under evaluation and have not been finalized. CMS is still analyzing input from various stakeholder groups on the matter.

Discussion of Recommendations among APOE Members and Dr. Clift

Following the presentation, the panel provided a series of preliminary recommendations, including incorporating patient experience into the hospital ratings; providing comments along with stars; using letter grades (A, B, C, D, F) rather than stars; and better explaining measures to consumers.

The panel also recommended including in the methodology for rating a hospital other factors such as inspections, audits, burnout, turnover, and HIPAA violations; and grouping by rural/urban, payor mix, teaching/nonteaching, how a hospital uses community resources, patient family involvement, and alignment with a Community Needs Health Assessment.

In addition, CMS should consider having more nuanced groups with a variety of domains that go beyond the number of hospital beds, which may be more relevant to some consumers. Consider that ratings may not be very helpful to rate prevention efforts, ambulatory care hospitals, post-acute care, and palliative care (which is under-reimbursed or non-reimbursable). Also, some patients may give priority to doctor star ratings (i.e., patient satisfaction) vs. hospital ratings.

Other recommendations included creating a CMS trademark (e.g., CMS logo with stars) that can be displayed by hospitals; having the CMS rating pop-up when an individual Googles a particular hospital; holding hospitals to a person-centered standard rather than risk adjustment; including measures for mediating social risk factors; and increasing predictability in scoring, which could incentivize hospitals to step up their game.

**Prevention X**

***Sandeep Patel****, Director of Innovation, Office of the Chief Technology Officer, U.S. Department of Health and Human Services (HHS)*

Healthcare for preventable non-communicable diseases, including heart disease and stroke, diabetes, and obesity, cost the overall U.S. health care systems more than $600 billion in 2018. Over 30 million Americans are now living with diabetes, 75 million are hypertensive, and nearly 40 percent of American adults are obese.

The CDC’s Three Buckets of Prevention framework categorizes interventions according to three discrete approaches on a continuum of prevention from healthcare to public health. These three categories (or “buckets”) are: 1) traditional clinical prevention, 2) innovative clinical prevention, and 3) community-wide prevention.

While these activities are promising, barriers exist and present challenges to scaling disease prevention programs. There are seven barriers to scaling prevention strategies:

1. **No clear efficacy and market validation pathways** for prevention strategies, such as those that exist for pharmaceuticals (e.g., clinical trial results, FDA approval).
2. **Long iteration cycles,** sometimes spanning decades, for developing, testing, and improving disease prevention programs, leading to low levels of innovation that scale beyond local communities.
3. **Failure to appreciate the complexity of behavior change at scale,** using methodologies such as human-centered design, choice architecture, and other behavior change strategies.
4. **Sparse innovation pipeline,** lack of financial incentives for investors to support entrepreneurs, and limited reimbursement incentives from insurers because benefits accrue to a more wide-ranging group of stakeholders.
5. **Prevention paradox,** where the highest number of cases are made up of low-risk individuals, making it difficult to identify appropriately targeted populations for prevention strategies.
6. **Difficulty to productize** prevention strategies, as opposed to pharmaceuticals, which can more easily be distributed around the world with minimal marginal costs and impact on efficacy.
7. **Intra- and inter-sectoral fragmentation** of data, cultures, regulations, and incentives, all of which impede free exchange of ideas and collaborative implementation of new platforms, interventions, and strategies for improving health outcomes.

To better address some of the above issues, HHS has released a Request for Information (RFI) that will be used to inform how HHS could catalyze the scaling and deployment of effective prevention strategies into today's social and economic environment. The period for public comment on this RFI began on October 24, 2019 and will end on December 13, 2019.

Discussion of Recommendations among APOE Members and Dr. Patel

Following the presentation, the panel provided a series of preliminary recommendations, including supporting public-private partnerships and incorporating other sectors (e.g., education) into prevention initiatives. CMS could also develop partnerships with CBOs, which have the trust of the community but may not have the necessary resources to implement prevention programs. Also, programs could be piloted in partnership with houses of worship which already hold activities throughout the week.

In addition, CMS could explore existing models such as Blue Zone Initiatives, Purposeful Communities, Life’s Simple 7 (American Heart Association), or other proven initiatives from the Robert Wood Johnson Foundation. The panel stated that many examples of prevention programs that work already exist. The key is to develop a sustainability model that goes beyond the pilot.

The panel recommended developing TV advertising related to prevention (e.g., public service announcements for positive teaching, advertise on children’s programming, posters in pharmacies focused on health education); developing something akin to the “the truth campaign” for prevention, through communications channels where younger generations prefer to obtain information; and leveraging existing online communities to support prevention activities.

Moreover, the panel recommended looking into safe and effective housing, as it can have a significant impact on health; ensuring that neighborhoods and parks are walkable; developing intergenerational prevention programs involving older/younger individuals; supporting prevention programs that focus on supportive housing, food for medicine, and connections to community resources; facilitating the connection between behavioral health and physical health through the use of technology (e.g., apps and portals); supporting data sharing among sectors (e.g., creating a health information exchange that includes data on crime, jobs, and other areas); developing interprofessional programs that could help children lose weight; and supporting curriculum education for providers on social determinants of health.

Public Comment

*Louise Knight, APOE Chair*

No public comments were offered.

Adjourn

***Lisa Carr****, DFO, OC, CMS*

Ms. Carr thanked all members and speakers for their participation. The meeting was adjourned at 2:50 p.m.