CMMI Beneficiary Engagement Listening Session: Incorporating Beneficiary Perspectives into Model Testing, Implementation, and Evaluation

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>> Adam Obest, CMS: Good afternoon, and welcome to the CMS Innovation Center listening session, "Incorporating Beneficiary Perspectives into Model Testing, Implementation and Evaluation." My name is Adam Obest with the Center for Medicare & Medicaid Innovation, part of the Centers for Medicare & Medicaid Services.

Before we start today's listening session, I would like to go through a few housekeeping items. As you just heard, the listening session is being recorded. Closed captioning is available for this event by clicking the CC button at the bottom of the screen. All attendees will be muted throughout this event. However, you can provide a written comment using a Q-and-A window on the bottom of the right of the screen. Your comment may be read aloud during the session later. Please indicate if you would prefer not to have your comment read aloud or to remain anonymous. If there is any press on this call, please submit questions through the CMS Media Inquiries portal. That link is now going to be shared in our chat window. Again, thank you so much for joining us today. I am now pleased to pass it over to Liz Fowler, the Director of the CMS Innovation Center. Liz, the floor is yours.

>> Liz Fowler, CMS: Thanks so much, Adam, and thanks to everyone for joining us today for a listening session that is all about the people served by our health system. The CMS Innovation Center, or CMMI, was created in 2010 as part of the Affordable Care Act for the ACA, with the goal of transforming Medicare/Medicaid into a more value-based health care system. Today, we want to take a step back and then ask how value-based care can better meet patients' needs. Administrator Chiquita Brooks-LaSure and others, including myself, who have worked on drafting and implementing the ACA, have always been most motivated by making the health system work better for all people. I could not be more thrilled to be working alongside Administrator Brooks-LaSure again as we center the voices of patients in every part of what CMMI does, as well as CMS as a whole. And for that reason, I'm very glad to have the Administrator here with us today to focus on and inspire our efforts to incorporate patient perspectives into the work we do. It's my honor to introduce Administrator Chiquita Brooks-LaSure. Administrator?

>> Chiquita Brooks-LaSure, CMS: Thank you so much, Liz, and it is really just such a pleasure to be with you all here today and to be working alongside Liz once again. I think that one of the things that's most important to us as a senior team here at CMS is the third pillar, which is making sure that we are incorporating the perspectives of people who depend on the three M’s: Medicare, Medicaid and CHIP, and marketplace coverage, into our conversation. And so, it's so important to us to hear from all of you about how we can best incorporate beneficiary perspectives into the testing, implementation, and evaluation of our Innovation Center models as we undertake a strategic refresh. We value all of you on this call as thought leaders on how Medicaid and Medicare beneficiaries view our newly-minted strategy, and we're extremely pleased to have you with us to help increase beneficiary awareness of CMMI, the Innovation Center, and what we're trying to accomplish, to improve our understanding of how we should best engage with beneficiaries to inform future models, and to provide invaluable insights into how we enhance our strategy by better incorporating beneficiary perspectives into our future models.

As you are all aware, over the past decade, CMMI has developed and tested over 50 health care payment and service delivery models. But going forward, we're refreshing CMMI strategy to advance value-based care. As you may know, our strategic direction is based on five pillars -- drive accountable care, advance health equity, support innovation, address affordability, and partner to achieve strategic transformation. To support and advance these pillars, we're using what we've learned from our previous models, and we're developing action steps to ensure that every CMMI model is patient- or person-centered. These steps include strengthening stakeholder outreach as well as strengthening our partnerships with beneficiary and patient groups such as yours. We're also pursuing every opportunity to incorporate beneficiary viewpoints and perceptions into every phase of the development and the release of CMMI models. We hope that beneficiaries, providers, patient groups, and others will soon notice these deeper partnerships, partnerships in which their needs and perspectives will inform model development, evaluation, and the definition of success.

As we continue to improve our models to ensure that they're truly patient-centered and beneficiary-focused, we'll be incorporating feedback from this and other sessions into our strategy. At its crux, our new CMMI strategy is not an endpoint but a launching pad. As with everything we're doing in CMS, we are particularly concerned about health equity and, without exception, we will be embedding it into every CMMI model. At CMS, "How are we promoting health equity?” is the first question we're asking, not the last. No person should be ever left out, left behind, or left on the sidelines when it comes to better health, better health care, and better coverage. I want to ensure you that our programs are operating to reduce the health inequities that underlie our health care system, which were especially illuminated by the COVID-19 pandemic. As the Reverend Dr. Martin Luther King Jr. noted, "Of all of the forms of inequality, injustice in health care is the most shocking and inhumane.”

So, what will be different for beneficiaries when we achieve an equitable health care system? What should we be measuring to see if our models are achieving health equity and closing disparities? And how can CMMI partner with community-based organizations to bring health care out of traditional settings and into our communities? These are some of the questions we are asking ourselves. But we cannot arrive at those answers alone. We need you to be our full partners in our efforts. We want to work with you. We want to learn from you and to listen to you, and we want to hear your ideas, your input, and your perspectives. Additionally, I want to assure you that our work together will always be a dialogue, not a monologue, as we work towards a health care delivery system that equally serves every American in every community.

I also have three asks for you today. First, we need input on how beneficiaries want to experience the health system, particularly at the point of service where they receive care. Secondly, we need your thoughts on how to improve health care services and delivery, including quality and affordability, for our beneficiaries, especially those in underserved communities. And, finally, we need your help to ensure that our CMMI models truly reflect the diversity of our beneficiaries. That's why I'm so grateful that you're here today with us for this listening session, helping to ensure quality, equity, diversity as our goals, and we hope that today's discussion brings a fruitful and ongoing dialogue on how to achieve this.

Thank you, and I hope this proves to be a productive session. I'll now turn back to Liz.

>> Liz Fowler, CMS: Thanks so much, Administrator Brooks-LaSure, for those motivating remarks. I am really looking forward to today's listening session and learning from our panelists and all of you in the audience about what more CMS can do to improve the care experience for our patients and beneficiaries. Improving patient care and patients' experience is the driving force behind our efforts to move the system towards value-based care, and in reflecting on the patients' stories we continue to hear, we know we need to do more to seek out patient perspectives. For all the time we've spent talking to health care providers and health care systems, we haven't spent enough time talking to patients. So, to get a better sense of patients' perspectives, we convened focus groups to learn what they think about the work of the Innovation Center. What we learned is that the language and terms we use are not resonating. The term “accountable care” was interpreted as skimping on care, not better care and care coordination, and the term “health equity” also doesn't resonate with patients, even though we think it's critically important.

We think that the work we're doing can lead better care and better outcomes, but we need to be more thoughtful about how we talk about our goals, how we define success, and that's really the key impetus for today's listening session. So, we'll start with a brief review of the Innovation Center's strategy refresh, the role of beneficiaries in our innovation models. This review will help us center on why the beneficiary perspective is so critical to advancing CMMI strategy over the next 10 years. Then, we'll hear from a series of beneficiary advocates and foundations and research experts regarding the experience beneficiaries have with our models and how, as a Center, we might be able to better engage this population in our work. We'll also reserve time for Q-and- A on the topics discussed today before closing with a preview of the steps we plan to take to ensure the input we receive today will inform future action.

To ensure that we have the opportunity to learn from all of you, I encourage you to submit questions throughout today's session by providing a written comment using the Q-and-A window on the bottom right of the screen. We'll be reviewing those closely and considering everything you share. From here, I'm going to turn things over to Purva Rawal, our Chief Strategy Officer, to talk about our strategy refresh and incorporating the patient experience. Purva?

>> Purva Rawal, CMS: Thank you so much, Liz. Good afternoon, everyone. We're really excited to have you joining us today. As I said, my name is Purva Rawal, and I'm the Chief Strategy Officer at the CMS Innovation Center. The Innovation Center, as many of you know, recently took stock of lessons learned during the Center's first decade and looked at over 50 models and what we've learned to help inform our strategic planning for the next decade. This work culminated in a new strategy refresh that aims to drive the health care delivery system for meaningful transformation, including a commitment from the Innovation Center to develop a deeper partnership with beneficiaries and patient groups. The refresh consists of five strategic objectives that you see here that are guiding implementation for our vision.

The first objective is to drive accountable care by increasing the number of beneficiaries in a care relationship with accountability or responsibility for the quality and cost of care that they receive. This objective should help reduce care fragmentation and cost by equipping providers with the tools needed to deliver high-quality, coordinated, and team-based care.

The second objective is to advance health equity by embedding equity in every aspect of our models and increasing our focus on underserved populations. This means we have to engage new providers and ensure that our model eligibility criteria don't disincentivize care for underserved populations.

The third objective is to support care innovations for patients and providers in a way to enable integrated person-centered care. This objective connects to knowledge sharing, care-to-care learning collaboratives, and will include closing care gaps and ensuring delivery of whole-person care.

The fourth objective is to improve access by addressing affordability through strategies that address health care prices, affordability, and the reduction of waste. This also includes the indirect costs that beneficiaries often experience as a result of a complicated health system, duplicative tests based on time navigating different providers and can lose time at work.

The final objective is partnering to achieve system transformation by aligning our priorities and policies across the agency and across CMS, but also by working with payers, purchasers, states, and especially beneficiaries, which is the focus of our discussion today. This will require new partnerships across the federal government and with many of the stakeholders I discuss today.

In our strategy refresh white paper released in October of last year, we emphasized a commitment to building a deeper partnership with beneficiaries and patient groups across the life cycle of our models, which we'll discuss more in a bit. And today's session is one of many ways we as a Center are driving deeper partnership with beneficiaries, patient groups, and providers to inform our models. On this slide, we take a deeper dive into two of the key lessons our team learned in developing new strategy and how the Innovation Center is leveraging these insights to ensure beneficiary needs and perspectives are at the center of model development, testing, and evaluation, and to extend the reach of value-based care in a meaningful way to all populations. As I said before, the Innovation Center is committed to embedding health equity into every model to ensure that the full diversity of Medicare and Medicaid beneficiaries are represented in the populations that we serve. We're working to design models that target participation among providers that care for underserved populations. This is going to require us to systematically evaluate the impacts across beneficiaries with different demographic characteristics, and, moving forward, the Innovation Center will need a consistent approach to assess model impacts on underserved populations and to better understand how to close disparities in care and outcomes.

For second, we're strengthening our stakeholder outreach. We're committed to deeper and more regular communication with a more diverse set of stakeholders. This process starts with engaging beneficiaries and patient advocates from the beginning, so their needs and priorities drive model development and then throughout the entire model life cycle. We also learned that many beneficiaries aren't aware their provider is participating in an Innovation Center model, so we also need to work with providers and hold new and consistent mechanisms for engagement with beneficiaries to better communicate what it means and what it should mean when they receive care through an Innovation Center model.

The idea of incorporating beneficiary input into the life cycle of our models is core to how our outreach is changing and what impact it will have on our collective work. To highlight how the Innovation Center will incorporate beneficiary input, this graphic details a series of potential questions and discussion items aligned to each phased of an Innovation Center model life cycle. So, the first is ideation and development. How does the model's theory of action or our hypothesis on how the model will impact quality, outcomes and cost align with beneficiaries' priorities? The second is recruitment and rulemaking. What kind of information about a model do beneficiaries want to understand? For instance, what will change in terms of the benefits or the services they receive? How might access to their provider change? The third is application. What communication tools are best for beneficiaries? How do we ensure that applicants, those that want to participate in our models, are reaching more beneficiaries, especially the underserved? Next is implementation and evaluation. Once a model is getting going, how are beneficiaries experiencing changes in the delivery of their care? Are they experiencing different health outcomes, changes in their quality of life? Are they feeling the impact of the theory of change that we started with at the very beginning? And then the last is scalability. If a model or features of a model are successful, how might this affect more beneficiaries? What positive impacts do they experience? And how can we build those into other programs that more can benefit?

This graphic provides a sense of how the Innovation Center will drive patient-centered care through model design delivery. It displays some of the opportunities that the Innovation Center can leverage to collect and incorporate stakeholder feedback, creating consistent feedback loops to inform our work. In the upper portion of the slide, we review the role the Innovation Center takes in designing and launching models and then evaluating the impact of these models on quality as well as patient outcomes and financial outcomes. The process is strengthened when we engage with stakeholders to determine how models are impacting different populations. There are many opportunities to promote this engagement and collect feedback for us to use before, during, and after the design of models, as I just described. And today's discussion is how we better systematically collect feedback from patients to inform our design and delivery.

Now, it's my pleasure to introduce Kate Davidson, the Director of our Learning & Diffusion Group, who will be moderating the panel discussion. Kate, the floor is yours.

>> Kate Davidson, CMS: Hi, everyone, and thank you so much for this. I'm Kate Davidson. I am the director of the Learning & Diffusion Group at CMMI. We're pleased to welcome several leaders from advocacy groups, a foundation, and a fellow payer to take part in a panel discussion about beneficiary engagement and CMMI models. Joining us today are Andrea Ducas, Senior Program Officer for the Robert Wood Johnson Foundation; Marjorie Waters, the Community Organizer at the Rhode Island Organizing Project; Lydia Isaac, Vice President of Health Equity and Policy at the National Urban League; Ramsey Alwin, President and CEO at the National Council on Aging; Frederick Isasi, Executive Director from Families USA; and Karen Dale, President, AmeriHealth Caritas DC and Chief Diversity, Equity and Inclusion Officer at AmeriHealth Caritas Family Companies.

During this panel, we will focus on the five objectives of the CMMI strategy refresh and the beneficiary perspective on each. The first objective is to drive accountable care by increasing the number of beneficiaries in a care relationship with accountability for quality and total cost of care. It's my pleasure to introduce Andrea Ducas, Senior Program Officer at the Robert Wood Johnson Foundation, where she works to transform health care systems and push for health care policy changes that have a meaningful impact on people's lives. Andrea is joined by one of RWJF' grantees in the Voices for Health Justice Program, Marjorie Waters from the Rhode Island Organizing Project. Andrea and Marjorie's backgrounds makes them perfect and ideal panelists to speak to our accountable care pillar.

Andrea, from your position at the Foundation, you work through your grantees to make sure you have an impact for patients in their communities. What are your thoughts on how the CMS Innovation Center can incentivize accountability in communities and between providers and the patients they serve?

>> Andrea Ducas, Robert Wood Johnson Foundation: Well, thank you for that question. And, just a reminder, for folks who are listening and may not be familiar with the Robert Wood Johnson Foundation, we are a national philanthropy that funds efforts to create a fair and just opportunity for health in America. And I work with a team that is focused on perpetuating that within the health care system and within governmental public health. And I would say to your question, Kate, the best way to start is by doing things like this and engaging in the kinds of activities that were highlighted already, which is listening to patients and talking with organizations that also know what matters the most to patients. There is a lot of information out there already about what it is that people care most about in their relationship with their health care providers, and it really truly is a relationship.

And I would think something that I have seen others find surprising is that there's this myth out there that patients don't really care about things like payment and delivery system reform, but we've seen that that's just not true. They care about it, but what they care about is not necessarily what the contracts look like and what modifiers are attached to a physician payment. But what they care about is what that actually means when it comes to what their interactions with the system look like. And when we talk to people, we funded a lot of research and talked with folks across the country about what it is they care most about at the end of the day with respect to their health care and their providers. Ironically, the degree of professional skill is not at the top of that list. At the top of that list is whether the care provider they're interacting with is going to treat them with respect, whether they're going to accept their insurance or, in this case, a referral to see them, whether that provider shares in decision making with them, is responsive to their phone calls, and then after all of those things, its has professional skill. So, the extent to which models actually effectuate those types of changes, that's actually going to resonate with the patient.

I think, you know, something we talk about in a lot of our efforts to reform payment and care delivery that Robert Wood Johnson Foundation supports, especially with respect to advancing health equity and speaking to patients' concerns, is, you really have to ground the why we're doing this in the experience of care for people. I think often, conversations around payment and delivery system change are really focused on value, on addressing costs, sometimes addressing crises. All of those things are appropriate, but you're not really going to get to a place where you're designing those models in a way that's meaningful to patients, unless the end goal is addressing one of those things. Is this change actually going to result in a provider being able to spend more time with their patients or listen to them or form a meaningful relationship? Is it going to offer the space for providers to actually engage in a respectful dialogue with their patients? If the answer to the question of why we're doing this and what expect to get out of it isn't those things, it's not going to actually match up with what patients expect and will give a bit of a misfire.

So, I think these types of dialogues are fantastic. I love that we have one of our grantees here, Marjorie Waters from the Rhode Island Organizing Project. She is going to be able to tell you, you know, what she hears from people, you know, especially from dual-eligibles, about what matters most to them, and I think this is exactly the kind of dialog that we're excited that CMS is engaged in.

>> Kate Davidson, CMS: Thank you so much, Andrea. I really appreciate your perspective in giving us some tactical and practical ideas about how to put patients at the center of the work that we at the Center and especially kind of demystifying some of the myths that are out there about engaging beneficiaries and patients in payment reform, so thank you.

With that, I'm going to hand it over to Marjorie. We'd love to hear, Marjorie, from you and your vantage point working with patients in their communities directly. What elements of accountable care are most important to beneficiaries across the continuum of health, so from those individuals with relatively low health care needs to those individuals experiencing high-risk chronic conditions? Marjorie?

>> Marjorie Waters, Rhode Island Organizing Project: Thank you so much for this opportunity. Just a little bit of a background, I have been organizing seniors and disabled adults under the banner of Voices for Better Health for the past 8 years. We are a grassroots organization, which means we directly interact with the community and perform listening sessions to understand better what their needs are.

The first question we asked when we began this, is what does it mean to age with dignity? You know, what does it mean to make the attempt to stay in your community? As we went on and the MCOs and the ACOs came into being, one funny comment was made: MCOs and ACOs and EIEIOs -- I don't know the difference. And I thought that was a good way to start off this conversation. You know, who guides patients through the acronym soup of health care? You know, they don't understand these acronyms. They're often explained in the language of health care bureaucracy and not in a language of the community. So oftentimes it goes over their heads, and nobody is willing to ask the question because they don't want to be the one who acknowledges that they don't understand what they've just been told. So, I think it's really important that we kind of back up a little bit and start explaining what an ACO is.

The other -- So that's part of how we can help patients better understand what their health care provides, you know, and just as importantly, what it doesn't provide, you know, so that there's clear expectations, you know, from the patient upon what they can expect from their health care. I think the biggest thing in explaining any of this is, you have to start all that: What's in it for the patient? You know, my first briefing on an ACO was solely PCP, you know, doctors, medical-oriented. And after the session, I asked a colleague, "So where does the patient fit into this model?" You know, so I was, you know, a little disturbed, and that's something that we need to do better. Most people do not know they're in an ACO and may not know until they have a negative experience, something like they need a referral, or, you know, they want to see somebody outside of network. That's when some issues can often arise. So, I think, you know, what they can do better is introduce themselves and explain why they think, you know, a doctor's office can explain what they think is going to improve in that person's health care. How does the ACO improve health care, you know? And that, unfortunately has not been very clear. We've heard this, you know, some vague information, like equity and diversity and cultural competency, but what does that mean to the patient? And, if you can't explain that in plain language, then there is a problem, because most patients won't continue to ask questions if they haven't understood the answer to the first one.

The other issue that I'm concerned with is, how are patient outcomes measured? You know, oftentimes, you know, and as an old six-sigma person, you know, I understand how important data is, but oftentimes, the measurements are developed from the top down, and I think it's critically important that CMS engage the community members and their patients in the measurement process, so that you have some metrics that come from the bottom up. Oftentimes, it's very surprising when you go out there that what you're measuring, and think is valuable and important isn't at all what the patient thinks is important. So, you know, once again, it's that communication. And I guess the last thing I'd like to say is that I encourage the staff of CMS, especially those who develop policy or administrative tasks, to attend at least one community listening session wherever they are, wherever they can, at least once a quarter. There is nothing like hearing it directly from the community, you know? I think you will gain insights into what the community understands about health care and what they need. Thank you.

>> Kate Davidson, CMS: Marjorie, thank you so much for sharing those insights with us. I do know that we love an acronym in health care, and I think it's really helpful to think about how we can talk with patients and beneficiaries about receiving care in an accountable care relationship. I also think that your suggestions around engaging in our own community is really helpful as well as thinking about how we can meaningfully engage with beneficiaries and measurement design, so thank you so much.

I'm going to move on to our second objective, which is to advance health equity by embedding equity in every aspect of CMMI models and increasing focus on underserved populations. It's my pleasure today to introduce Dr. Lydia Isaac, who is the Vice President of Health Equity and Policy at the National Urban League. Dr. Isaac has extensive experience working to translate research into policy and practice to promote health for all persons. Her background in local and state governments and research experience make her a wonderful analyst to speak to our health equity pillar. Dr. Isaac, what do you think, from your perspective, should be different for beneficiaries so we do achieve an equitable health system? And what should we be measuring to see if our models are closing disparities? Dr. Isaac?

>> Dr. Lydia Isaac, National Urban League: Thanks, Kate. I appreciate the invitation to be on this panel and wanted to say, like everybody else, a little bit about the National Urban League, which is a historic civil rights organization that fights for Black American populations.

And so, the interesting part, I want to echo some of what Marjorie and Andrea said about this idea of really meeting communities where they are and thinking about them as a whole person. In terms of, you know, health care access -- The previous panelists did talk about, you know, the patient voice, community voice, but understanding that a patient is just beyond their conditions and really thinking about how the social determinants of health in particular impact the ability of a beneficiary or a patient to navigate the health care system, to navigate their disease management, to really think about the work that takes to be healthy. And so, it's really important for us to think about the linkages even though, you know, CMS may not be able to address all of the social determinants of health in its models, but understanding that being able to make linkages for patients because they're in this vulnerable space when they come to meet their provider is a wonderful opportunity to get them the resources and help they need, particularly for dual-eligibles, particularly for vulnerable populations. It's understanding how we go out into the community and use community-based providers and community services to connect them to the other services that the need that are going to support their ability to carry out disease management programs, to carry out health-promoting activities.

And so, it's really important, I think, for our communities to feel like, as, I think, Marjorie made a really good point, that they are active participants in their health care, that they're being collaborative, that their providers and the systems around them are being collaborative and helping them to achieve their goals. And those goals may look different than, you know, what we say the quality measures are. And we have to meet patients there in saying, "Okay, the quality measures may say this, but I see you're doing this, and that's actually really good," and let's -- How do we encourage that? How do we reduce barriers to access those kind of services and materials that patients need to make the smaller goals? They might be more incremental goals, but they're getting there. And patients really want to feel like active participants, and I think that's really important. We talked about the acronym soup that we throw at patients and what they're supposed to know, and I think they also want to feel like, "I'm a whole person, and you're thinking about my care on a coordinated level, a coordinated, connected level." And sometimes the disjointedness of our system makes patients feel like people are not listening to me, people are not understanding what's going on in my life, people are not, you know, talking to each other to coordinate my care. So, it's really important, particularly for populations that may not have access to all the resources who may be on low literacy level, who may have lower incomes that doesn't allow them to supplement services, that is provided with other methods to really feel like people are out for their well-being. And so, I think it's really important about those linkages and activity and really thinking like they're active participants and being active in their health care.

And in terms of, I think, our second question, Kate, was measurement. I'm going to go a little bit back to something Marjorie said about not only having our measures, which are important clinical measures – quality measures are important for what we do work – but also measures of satisfaction. Did linkages happen? Did barriers get reduced in order for patients to be able to carry out the disease management plans, for example, that their providers may have instituted? Did they understand what they were supposed to do? Those are really important measures because those are barriers that actually we can reduce in our models, and so being able to understand what those barriers are and how the Innovation Center can institute models to reduce those barriers within and outside the system is really important. I'm going to stop there.

>> Kate Davidson, CMS: Thank you so much, Dr. Isaac. You really built on the themes from our previous two speakers, and a lot of these things are coming together and very clear that we need to align our work with the patient goals and really focus there as well as to create a collaborative and coordinated system, so thank you so much for your thoughts on that.

So, our third objective within the strategy refresh that we've recently released is to support care innovations to enable integrated person-centered care through things like actionable practice-specific data, technology, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibility. We're going to move to our panelist in just a minute, but before we do, we're going to launch a poll now. We'd like to hear from you and from your perspective about what is most important to beneficiaries. So, we're asking here, what are the top two tools or technologies listed below that can improve beneficiary care and engagement with their care teams? You can go ahead and select two. The options are telehealth, for example, through video or phone, enhanced communications options, such as texting or online chatting from a provider, applications that support treatment and health care decisions or access to community-based coordinated care. I'll give you guys a second to answer those questions. Thank you so much. And so, it's looking like all of these things are important. We've got a lot of feedback, especially on access to community-based, coordinated care, lots of even feedback around telehealth options and enhanced communication options, as well. Thank you all so much for that feedback. I'm going to move us on to our next panelist.

And it's my pleasure to introduce Ramsey Alwin, who is the president and CEO of the National Council on Aging. Ramsey is a thought leader and policy advocate who is leading a nationwide movement to ensure equitable aging for every American. And she's going to speak to our support innovation pillar to answer the following question -- What tools and technologies improve the care beneficiaries' experience, engagement with their care team, and what tools and technologies assist and take burdens off of caregivers? Ramsey?

>> Ramsey Alwin, National Council on Aging: Thanks so much for having me. It's such a pleasure, and I'm so very grateful to have the opportunity to share NCOA's perspective on innovations and tools and technologies to improve the experience and engagement of beneficiaries and their caregivers. And at the National Council on Aging, we work every day with tens of thousands of community-based organizations that are working to address social determinants of health, basic needs and a variety of support services that allow individuals to age in their home. So, I'm so pleased to see that is a high priority, given our conversation today.

At NCOA, we believe economic security and healthy aging should be a right, not a privilege. We focus on the needs of diverse older adults and all the challenges they experience, the disadvantages, the vulnerability, and the need to get more targeted support to them. At NCOA, our Center for Benefits Access leads the Medicare Improvements for Patients and Providers Act, or MIPPA Resource Center, nationally, supported by the U.S. Administration for Community Living. This center offers tools and training to help counselors find and enroll low-income people with Medicare benefits, benefits that can subsidize the cost of premiums, co-pays, and out-of-pockets, saving dollars on those health care expenses, those prescription drugs. And we also take that touchpoint and extend it to help individuals find supports for food, or shelter, for other basic needs, really maximizing that moment. We also support state health insurance assistance programs and benefit enrollment centers across the country. We understand firsthand the challenges as well as the opportunities to engage and empower beneficiaries with the information they need to make health care benefit decisions, and technology can be a huge vehicle for that transformation.

CMS' Medicare Plan Finder is an important tool to compare coverage options, shop for plans, and help Medicare beneficiaries navigate the increasingly complex ABCs and Ds of the program, that alphabet soup that was mentioned earlier. We appreciate CMS' commitment to continuously improve and enhance Plan Finder. However, as a growing share of Medicare population opts for enrollment in Medicare Advantage plans, we recognize that further innovation is required to ensure beneficiaries have the appropriate information they need to select coverage that meets their needs. Significantly more transparency on the supplemental benefits offered by Medicare Advantage plans is critical, such as more details on what is specifically provided in the supplemental benefits eligibility and allowed frequency of benefit use. Standard information about the supplemental benefits should be mandated by CMS and provided in the Plan Finder. We also request that CMS provide greater transparency in collaboration with Medicare advocacy organizations regarding beneficiary surveys.

Additionally, many states offer ways for people duly eligible for Medicare and Medicaid to receive integrated care that is coordinated to meet all of their needs. But these plans are only useful when people are aware of and are able to access them, another opportunity for tools and technology. NCOA has been working to expand a digital support tool originally developed by the Scan Foundation, coined "My Care, My Choice," that educates dual-eligibles about their options. But this tool thus far is limited to only a few states. We see an opportunity for CMS to expand awareness and knowledge of integrated care options for dual-eligibles through continued innovation and transparency of the Medicare Plan Finder, making it easier for beneficiaries and caregivers to identify these special-needs plans on the Medicare Plan Finder and understand their benefits. It would increase enrollment and help with quality and accessibility.

NCOA has also developed a free online tool Benefits Checkup that helps individuals identify what benefits they're eligible for and assist in the application process. This tool includes the Part-D low-income subsidy and Medicare savings program that are so critical for low-income beneficiaries. Public education and visibility around this tool are needed, such as a link on the Medicare Plan Finder or Medicare.gov would go a long way. We certainly understand the importance of always leveraging technology and tools to improve the health care experience for Medicare beneficiaries, but I would be remiss if I didn't acknowledge that the digital divide is real. And for those that don't have access to broadband and technology, can't benefit from these tools or telemedicine due to the lack of digital literacy or connectivity, hardware, or software, we really need to invest and support innovation, keeping an eye to equitable access and ensure these individuals are not left behind. So, for example, many Medicare beneficiaries are only able to use 1-800-Medicare due to access challenges. We recommend more staffing and investment in the call center personnel to reduce call hold times and increase expertise. More support is also necessary for the Medicare shift programs to reach more people one-on-one to counsel them on their questions and their options. Shift funding has not kept pace with inflation or the growing demand.

Thanks so much for the opportunity to share our perspective and I look forward to any questions or more detail I can share.

>> Kate Davidson, CMS: Ramsey, thank you so much for sharing your perspective. You gave us some really tangible feedback, especially around Plan Finder and how we can be more transparent, so thank you so much for joining us today.

I'm going to move us on to our fourth pillar, which is addressing affordability. And, again, I want to hear back from you all in the audience and your perspective. And so, we're going to launch a second poll now. The poll question is, what two elements related to affordability are highest priority to beneficiaries? And it's multiple-choice, and we're asking you to select two, so monthly premiums, prescription drug costs, indirect costs such as transportation, childcare, leave from work, loss of wages, duplicative tests or visits, cost transparency, predictability, and level of cost sharing.

Thank you, guys, so much for your feedback on this poll. It looks like we've got a lot of folks that are recommending prescription drug costs as a very high priority for beneficiaries and monthly premiums, indirect costs, et cetera, so thank you. We will definitely be using this feedback to inform some of our internal thinking.

It's now my pleasure to introduce Frederick Isasi, who is the Executive Director of Families USA, one of the nation's leading nonprofit health advocacy organizations. As a national thought leader and subject matter expert on the social issues and solutions surrounding health care affordability, Frederick will offer his thoughts on our address affordability pillar. Frederick?

>> Frederick Isasi, Families USA: Hi, Kate. Thank you so much. It is such a pleasure to be here, and what a great conversation, so a very big thank-you for inviting Families USA to participate. There are three main points we were hoping to cover and respond to your questions about affordability, and they are strongly supported by the earlier comments that we just heard from other panelists.

First, health care affordability is a central concern of most families. The majority of people across this nation live with the anxiety that one or more medical bill will devastate them economically. And most people believe that the health care sector is operating in the interest of the business of health care and not the interest of the patients it purportedly serves. Second, there is no question when people are asked, and most important concerns around affordability relate to periodic or recurring needs like cost sharing or prescription drugs or outpatient treatments. We just saw that as well as monthly premiums. However, the deeper answer is that consumers and patients know the health care system has lost its way. They are deeply frustrated with the very high cost of health care because there is a real sense for all of the money that we spend, we aren't achieving the health that we deserve as a nation. And then that leads to my final point, which is, to really deliver for our nation's families, affordable access to health, be it in Medicare or Medicaid, CHIP or the Health Insurance Exchanges, the brilliant folks, all of you guys working so hard at CMS and HHS, could think about the leverage they can pull that will reorient the health care system to actually deliver health for our families, not just the economic policies but policies across the really vast authorities of HHS.

So, let's take each point one by one. First, health care affordability is an essential concern for most families, and what do we know? Almost half the public, 44%, don't go see a doctor when they need to because of cost. 30%, about a third of Americans, report medical care interferes with their basic needs, things like food, housing, heat. 74%, so three quarters of the public, feel that we don't get good value from the US health care system, and almost 80% of the population think that the government should help make sure everyone has access to affordable, quality health care. So, the American people aren't confused and are deeply frustrated, and most importantly, their personal health and economic security are threatened. And this issue has deep equity implications. According to our own original research at Families USA, working-class Americans are most likely to report missing doctor visits because of costs, and hardest hit are women of color and, in particular, women of color in rural America. The ACA made a huge dent in this problem, but there remains about a 25% increase even after the ACA of folks missing doctor visits because of cost. So that leads to my second point. There is no question that the most significant concerns around affordability that people discuss relate to periodic recurring needs, things like prescription drugs, outpatient treatment, and monthly premiums. In all of this by far, prescription drug costs are one of the largest complaints of consumer, but let's examine why.

First, so many drug companies' prices are so abusive and go up so fast, so this is so well-documented. The public is very aware of it, and we need to talk more about the research if folks want to talk about it. But there's this really abusive pricing structure. Second, the abuse is so rampant that consumers experience prescription drug increases when they walk into the pharmacy to pay for their insulin, their statin or chronic cancer medication. That moment, paying at your local CVS or Walgreens pharmacy counter is where the American people get a first-hand view of how irrational and abusive the health care sector has become. Drug prices can go up not just year over year but month over month, often two or three times faster than our paychecks. And the same thing is happening in a more opaque way around health care premiums. For example, since 1999, premiums have risen so quickly that now, the employee share of premium cost is the same as what employers were paying back in 1999. We're talking about premium increases in the last few years that are three times' faster than our paychecks.

So where does leave us? You all know we are often spending 30% to 50% more than other nations for our care, and almost all of this relates to the fee-for-service drive towards higher prices and increased volume. Our overall health outcomes are worse, and importantly, you've also seen the startling difference between payment rates in government programs like Medicare and Medicaid versus private insurance. In some markets, private payers are paying two or three times more than Medicare, and so we squeeze that balloon on price and volume in public insurance programs. The hospitals, corporate position groups and drug companies don't evolve, react towards achieving health. They take the shortcut and raise prices where they can, the private sector. And of course, it doesn't just create tremendous financial insecurity for the overall 150 million Americans who are using ESI or coverage in the exchanges but also is a real threat to access for beneficiaries as private pay patients become a bigger and bigger portion of the profitable business of health care.

So, this leads to my final point. To really deliver for our nation's families affordable access to health care, it's critically important that we recognize how much the health care sector has lost its way. I spent a really interesting part of my career working behind the curtain with the CEOs of large health systems and corporate physician groups, and they know exactly how distorted the health care delivery system is and now work with high-powered consultants continues to leverage these distortions from using the most expensive devices, prescribing the highest-cost oncology drugs, pushing high-priced back surgeries with terrible outcomes, or charging outrageous price increases by capturing key specialists within a market. They are not confused.

So, we urge all of you, this really hardworking group at CMS and HHS, to think about this problem not just as a surgical intervention around a particular problem, for example, sham stints or outrageously priced drugs, but really, how do we create meaningful guardrails around the health care sector that can truly reorient our health care system to deliver health for our nations families. And, yes, of particular concern to CMMI, let's tackle those truly out-of-control economic incentives in fee-for service health care. Use really powerful new economic models that allow providers, willing and able to truly invert their business, to make money by doing what's best for patients to share risk. But also think about the other ways the tail is wagging the dog in the current system of health care. For example, tackle transparency. Use your power to require that interoperable data are available and used to unveil all of this waste, the outrageous prices, and poor outcomes. Think about the behavior change that would occur if a local paper could write the story about the must-have teaching hospital providing useless or harmful care and price gouging. Unveil unusual bully pulpit to spotlight abusive pricing across the sector, particularly premium increases that are so conveniently opaque to most consumers. Support efforts to develop protections, economic shields for consumers, from being harmed by the fee-for-service health care system, things like really well-conceived value-based insurance design or economic alignment with primary care providers to allow these providers to more effectively steward their patients through the system and, God forbid, prohibit efforts by industry to veil outrageous prices for low-value care through the use of things like co-pay coupons or strategically reduced cost sharing. Think also about how your policies can embrace new models of care including new evidence-based, culturally appropriate workforces like community health workers, advanced-practice dental hygienists, and peer support specialists.

Finally, and most importantly, as you are in a state of transformation, collaborative initiative that just launched the coordinated care organizations and the accountable communities of health, find the regulatory pathways to reorient wasteful spending away from high-cost, high-margin sites of physical care and into community-led and -centered efforts to address the most powerful drivers of health and social determinants of health. Importantly, in those efforts, patient and community perspectives have to be centered in the transformational enterprise intentionally with key data and political support in a backbone organization to push past the powerful health sector's interest in status quo and towards transformation.

So, in short, it's a really complex problem. Thank each of you for using your channels to solve it. The health and the economic well-being of hundreds of millions of children, women, and men rest on your success, and we are here 100% to support you and partner with you. So, thanks again for inviting families to participate in the discussion.

>> Kate Davidson, CMS: Thank you so much, Frederick. You always know how to take a really complicated topic and bring such clarity and focus through some of your examples with, you know, 50% of Americans deciding not to go to the doctor because they can't afford. So, I think that really helps us to stay narrowed in on what our goals are.

So, I'm going to introduce our final panelist now, who's going to speak to us about partnering to achieve systems transformation by aligning priorities and policies across CMS and aggressively engaging payers, purchasers, states, and beneficiaries.

It's my pleasure to introduce Karen Dale, who is the President of AmeriHealth Caritas DC, one of the largest Medicaid-managed care organizations in Washington, DC. Karen has guided implementation of innovative approaches to managing the complex needs of persons with multiple health risks and coordinated many collaborative relationships to move innovation forward. Karen will offer her thoughts on our partner-achieved systems transformation pillar. She'll answer questions about how the Innovation Center can better engage and partner with beneficiaries, patient groups and community-based organizations, which we've heard a lot about today, to advance person-centered care and transform the health care system and how our engagement approach might vary depending on the types of beneficiaries we're seeking to engage, so Medicare fee-for-service, dual populations, Medicaid and Medicare Advantage. Karen?

>> Karen Dale, AmeriHealth Caritas DC: Thank you. I read a statement recently that I want to share with everyone. It said, "Conversation is where change begins, where hearts and minds are changed, and we all have the power to change the conversation.” So, I'm thankful that we've had this time and all the amazing panelists, who have provided us with really great feedback. I would add, importantly, we must demonstrate transparency, openness, and humility in every conversation as we seek to engage patients. So, what might this type of engagement look like? I like that Administrator Brooks-LaSure used the word, “partnership.” For a successful partnership to occur, each party has to invest, and in health care and in government, we have work to do to invest more in the relationship. And this relationship, we must recognize, requires maintenance. So, it's not a one-and-done, when we get what we want out of it, we're done. It's a continuous recalibration and investment.

Second, we require inclusion to be more front-and-center so that beneficiaries, community-based organizations, are truly offered an opportunity to serve on committees where strategies and discussions are happening prior to decisions being made. I like that Ms. Rawal said in that grid that she showed, right, that there should be engagement all along the process so that ideally it would always begin with that first box: ideation and development. We have to work to provide education, we've heard from many of our panelists, in ways that it's just -- It's all plain language, and I always suggest if you start with what I'm most interested in, I am listening even more, and so starting not with the model but starting with the impact to who we serve, the understanding about why and, again, back to plain language. We also, I believe, have missed an opportunity to help providers to explain things to their patients in plain language. Sometimes we end up with more of a negative perception from the patient because a provider can't explain. So, they're just like, yeah, you know, they're just always passing down these rules and blah, blah, blah, right? So, we must engage the providers, as well, so that they can reinforce the messaging.

Finally, in this piece around inclusion, recognize that it may not be easy to get the messages across even when we're using plain language because we're battling mistrust and misinformation. So that goes back to my point about educating providers, as well, so that they can help to reinforce messages. We talk about person-centered and whole-person care. However, you can't get to that, in my estimation, if we don't start with human-centered principles in what we are talking about doing. So, that means we have to first get to know people, understand their needs, preferences, and experiences, before we jump to that we're going to take care of all of what you might need, right, because we don't know that yet. We don't know that yet.

So, taking the time to take a more human-centered approach where we get to know the deep experience people have had as patients, trying to navigate our system, helps us to cultivate empathy, which then supports us to think more broadly and deeply about how we create these models. And in order to achieve health equity, the attainment of the highest level of health for all people, we must focus and include subpopulations and marginalized communities, and these are communities that are often going to have the least trust and who have been harmed the most in our system. And so, we must take the time to build the relationship, coming with humility to help to address the harms that have occurred. There's also the importance of focusing on why in a way that builds trust, again, putting the patient first in how we describe what we do. And you've heard, again, about transparency, sharing information broadly all along a process for improvement so that we're generating more understanding and connections. Did you want me to answer the other portion of the question, Kate, as well?

>> Kate Davidson, CMS: Yeah, why don't you -- If you have any thoughts about it, we would love to hear from you, Karen.

>> Karen Dale, AmeriHealth Caritas DC: Sure. so, the question was around, you know, how would we maybe use different engagement approaches depending on the type of beneficiary -- Medicare, fee-for-service, dual, Medicare Advantage, or Medicaid. I believe that the approach doesn't vary that widely if we are focused on key principles such as a willingness to adapt and go to where the beneficiaries are literally and figuratively. There shouldn't be these walls where we only invite people in at certain points where we want something. We want input. If they knew that they could always provide support and recommendations, that would really be helpful I love the recommendation I heard about CMS leaders engaging directly. I love that you all have a call center. It gives a great opportunity for you to listen to calls. I listen to member-facing calls all the time. I make the time to do that because it is so informative about the experience of who we serve.

Removing the jargon, you heard about that in the alphabet soup, removing the bureaucracy, and using words that really help people to feel that they belong. Sometimes when we're talking about what people must do, should do, referring to them as being noncompliant or even when we're focused on more of where the deficits exist such as, I get it, it's a thing, to say low health literacy.

However, what does that mean? If we look in the mirror, have we done all we could to make it so that information was digestible and palatable? And I believe and I have observed that there is so much more we could do to improve the language that we use. Leverage our community-based organizations who have the trust often, who have been engaged and standing right next to who we serve in terms of understanding their experience. They have a wonderful role that they can play to help to build better relationships for us and to bridge the gap until we get there. And finally, for persons being served in Medicare and Medicaid and Medicare Advantage, we probably want to think about how to create a meaningful role for the caregivers to also provide input.

>> Kate Davidson, CMS: Thank you so much, Karen. I think that your comments were really helpful and brought home the reason that we're doing this work. It's about relationships. It's about people, and it's about their communities, and that was echoed, I think, across all of the speakers.

I want to thank all of our panelists today for your thoughtful responses and contributions both to the field and to the conversation. I'm going to wrap us up now because we wanted to have a little bit of time for questions and answers, but it looks like we've run out of that time, and so we apologize for that. However, we will be circling back to those questions that were put into the chat that we were unable to answer today.

We really appreciate everybody attending. Please, we'd love for you to continue to participate in beneficiary engagement events. We will be continuing these conversations.

Please also follow us on Twitter @CMSinnovates, and feel free to provide any additional input and e-mail your comments at CMMIStrategy@cms.hhs.gov using the subject line, "BENEFICIARY LISTENING SESSION." You can also visit us on the CMS Innovation Strategic Direction web page where you can find a new resource, "At-a-Glance," that provides a summary of the strategy refresh.

And also feel free to sign up to provide or to receive regular e-mail updates.

And with that, I'm going to close us out and offer a huge thank-you to our panelists for launching us into this really important conversation. Thank you all and have a good day.

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