EXECUTIVE SUMMARY

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

APRIL 20, 2023, 8:30 A.M.– 4:00 P.M.

Open Meeting

Walter Gutowski, *Acting Designated Federal Official (DFO), Senior Advisor, Partner Relations, Office of Communications (OC), CMS*

Mr. Gutowski opened the meeting and called it to order at 8:43 a.m. (EDT). He introduced himself as the Acting Designated Federal Official (DFO) and reviewed housekeeping items to ensure compliance with the Federal Advisory Committee Act (FACA). First, he announced that APOE will have the opportunity to hear public comments later in the meeting, and any individual wishing to give public comment should sign up at the registration desk, noting that the time is set aside for comments only. Next, in compliance with a White House directive, he asked that lobbyists identify themselves as such before speaking. Finally, Mr. Gutowski stated that he can be reached at Walter.Gutowski@cms.hhs.gov regarding FACA compliance questions.

Welcome and Opening Comments

Stefanie Costello, *Director, Partner Relations, OC, CMS*

Ms. Costello thanked the APOE members for joining the meeting in person and previewed the agenda for the meeting. She then turned the meeting over to Dr. Margot Savoy, APOE Chair, for her opening comments.

Opening Comments and Panel Introductions

Dr. Margot Savoy, *APOE Chair*

Dr. Savoy greeted participants and thanked members for meeting for the first time in person since the onset of the COVID-19 pandemic. She instructed meeting attendees to turn their nametags around to seek recognition from the Chair to discuss or make a comment. She noted that this meeting is open to the public and the press—all discussion is on the record. She stated

that the opinions expressed by panel members are those of the individuals and not the organizations with which they are associated. Dr. Savoy recognized Ms. Cheri Lattimer, APOE Vice Chair, and asked her to provide opening remarks.

Ms. Lattimer thanked Dr. Savoy for her leadership and expressed appreciation that APOE members could meet in person.

Following Ms. Lattimer's remarks, Dr. Savoy conducted a roll call with the APOE members. After each panel member introduced themselves, she turned the meeting over to Mr. Gutowski for a presentation.

Certificates of Appreciation for Departing Panel Members

Stefanie Costello, *Director, Partner Relations, OC, CMS*

Walter Gutowski, *Acting DFO, Senior Advisor, Partner Relations, OC, CMS*

Ms. Costello and Mr. Gutowski presented certificates to APOE members whose terms expire on June 1, 2023. The members are Julie Carter, Jean-Venable "Kelly" Robertson Goode, Scott Ferguson, Cheri Lattimer, Michael Minor, Margot Savoy, Congresswoman Allyson Schwartz, and Tia Whitaker.

Ms. Costello stated that APOE has an excellent reputation throughout CMS—staff always receives a good response when presentations for APOE meetings are solicited. She thanked Dr. Savoy and Ms. Lattimer for their leadership as Chair and Vice Chair of APOE.

Mr. Gutowski announced that starting with the next meeting, Neil Meltzer will serve as Chair, and Carrie Rogers will serve as Vice Chair of APOE.

CMS Response to APOE Recommendations from February 2023 Meeting

Stefanie Costello, *Director, Partner Relations, OC, CMS*

Ms. Costello informed APOE members that APOE's recommendations from the meeting on February 9, 2023, are included in the meeting packet. APOE members did not have any questions about these recommendations. Ms. Costello returned the discussion to Dr. Savoy to introduce the first set of speakers.

Improving Medicare Enrollee Utilization of Diabetes Prevention and Treatment Services

LaShawn McIver, MD, MPH, Director, Office of Minority Health (OMH), CMS

William J. Mayer, MD, MPH, Expert Consultant, CMS Fellow, and Health Insurance Specialist, CMS Federal Coordinated Health Care Office

Dr. McIver introduced the priorities and goals of OMH. She stated that OMH was tasked with assisting CMS to develop strategies for preventing diabetes, as announced at the White House Conference on Hunger, Nutrition, and Health. Dr. Mayer presented several CMS statistics. Three out of four Medicare beneficiaries have diabetes or prediabetes—this is expected to increase over the next 25 years and is a significant driver of hospitalization, amputation, blindness, and heart attacks. Less than 4% of Medicare beneficiaries have received diabetes screening services, less than 1% have received Intensive Behavioral Therapy for Obesity, and less than 1% have utilized the Medicare Diabetes Prevention Program (MDPP). Diabetes Self-Management Training (DSTM) can reduce mortality by 25%, but only 5% of Medicare beneficiaries use it.

Dr. Mayer explained that Comprehensive Diabetes Care consists of an annual eye exam and an annual primary care visit to assess and manage blood glucose, blood pressure, feet, ankles, footwear, atherosclerotic heart disease, and chronic kidney disease. However, for utilization statistics, only 36% of Americans aged 18 years and older with diabetes met all goals for A1c, blood pressure, cholesterol, and non-smoking. Cost-sharing is a barrier to receiving the services.

Dr. Mayer discussed Medicare Programs Addressing Health-Related Social Needs (HRSN). Advance payments to address health-related social needs are available to some new Medicare Shared Savings Program (MSSP) Accountable Care Organizations for two years. Medicare Advantage Plans have a new requirement to assess HRSN, and a voluntary HRSN screening measure is offered for the Medicare Quality Payment Program. Current program limitations include a lack of data on the prevalence of HRSN, receipt of HRSN benefits, race/ethnicity, and no coverage for community health worker services.

Finally, Dr. Mayer discussed previous communication efforts to increase awareness and education. These tactics include stakeholder engagement, the Medicare Learning Network, social media, earned media, 1-800-MEDICARE, email content, and working with regional offices.

Discussion of Recommendations Among APOE Members, Dr. McIver, and Dr. Mayer

Increase Receipt of Diabetes Prevention and Control Services: Increase access to services through telemedicine and digital health to provide access to information about health-related

social needs like food insecurity and housing insecurity. Package and summarize MDPP program information for behavioral psychologists. Create a mobile app that provides access to information about health-related social needs like food and housing insecurity. Create specific, separate communications on pre-diabetes.

Reducing Barriers to Promote Receipt of Diabetes Prevention and Control Services by Medicare Enrollees: Provide pre-testing and screening services in the community (e.g., at a barbershop or place of worship) instead of requiring a medical visit. Use impactful incentives, including non-financial incentives such as free, healthy food or discounts. Reduce the cultural stigma surrounding care; engage with non-traditional health care providers (i.e., "Western" medicine). Improve the availability of incentive programs that offer a bonus payment for weight control and achieving weight goals.

How CMS Can Advance Health Equity in Diabetes Prevention and Control: Shift towards prevention and lifestyle changes to reduce the costs of treating conditions like amputations and eye issues—flag diabetic patients who visit the emergency room three or more times. Incentivize whole-person care. The reimbursement structure for annual wellness visits is not conducive to preventive care. Encourage providers to provide wellness visits and other programs by making the physician fee appropriate for the value of their service. Reduce the stigma surrounding accessing care, such as through telemedicine appointments. Telehealth can be less intrusive for people who feel embarrassed about their health.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care—Resources for Health Care Professionals

Darci Graves, *Technical Director, OMH Front Office, CMS*

Shannon Ward, *Public Health Advisor, Program Alignment and Partner Engagement Group, OMH, CMS*

Alexandra Bryden, *Technical Advisor, Program Alignment and Partner Engagement Group, OMH, CMS*

Ms. Graves provided a history of the development of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The Department of Health and Human Services (HHS) Office of Minority Health developed CLAS in 2000 and updated it in 2013. CLAS is a blueprint of 15 standards, consisting of one principal standard and 14 divided into three domains: Governance, Leadership, and Workforce; Communication and Language Assistance; and Engagement, Continuous Improvement, and Accountability.

Ms. Ward discussed examples of available CLAS-related resources. These included "Building an Organizational Response to Health Disparities: Five Pioneers from the Field," a resource containing five case studies; "Diabetes Prevention Programs: Equity Tailored Resources," 16 sets of culturally and linguistically tailored materials on type-2 diabetes prevention; a "Guide to

Developing a Language Access Plan," a resource containing steps on how to make a plan for patients with low English proficiency; and "Improving Communication Access for Individuals Who are Blind or Have Low Vision," an organizational assessment tool for improving services to patients who are blind or have low vision.

Ms. Bryden concluded that the White House, HHS Secretary, and CMS are interested in how to best implement CLAS. There are resources across agencies, but she saw a gap—there needs to be more resources specifically tailored for health care professionals. CMS wants to create a toolkit for health care professionals and is seeking feedback from APOE on what to include.

Upon the conclusion of the presentation, Dr. Savoy opened the floor for questions.

Question 1: CLAS was last updated in 2013. Are there any plans for a refresh?

CMS Response: We are not aware of any current plans. Because CLAS was developed by the HHS OMH, a different OMH from the CMS OMH, they would take the lead on future updates.

Question 2: Are there mandatory CLAS compliance rules?

CMS Response: CLAS standards currently do not have teeth because they are not an exercise of statutory or regulatory authority. They are tenants and a tool to help organizations implement other legal requirements contained in statutes such as the Americans with Disability Act and various Executive Orders.

Question 3: Is CLAS compatible with states who do not allow the discussion of specific topics such as sexuality or race?

CMS Response: CLAS standards themselves are not regulations. They are tenants.

Question 4: Is CLAS incorporated within the National Committee for Quality Assurance (NCQA) standards?

CMS Response: Yes, we believe CLAS is compatible with NCQA and Joint Commission standards.

Question 5: What is the desired outcome of implementing these standards in a toolkit?

CMS Response: Research shows that CLAS implementation can increase health equity, a good practice that lowers health disparities amongst different populations. Further, there is a recent activity with proposed rules and regulations surrounding health equity outcomes, so the timing is right to have this toolkit available as a resource.

Discussion of Recommendations Among APOE Members, Ms. Graves, Ms. Ward, and Ms. Bryden

Recommendations for the CMS CLAS Toolkit: Use examples of successful implementations from other organizations, such as pictures, video links, and templates. Develop a gap analysis tool that is customizable for different organizations. Clearly connect case examples and how they relate to CLAS standards to help organizations understand how to implement certain practices. Include short videos and media materials that are customized and co-branded in the CMS CLAS toolkit. Develop a crosswalk for how CLAS helps implement other requirements/regulations, such as NCQA or Joint Commission standards. Align the toolkit with existing compliance mechanisms to ensure its implementation and update compliance.

Other Topics or Audiences and Populations CMS Should Incorporate: Medical and nursing education providers should target an early understanding of health equity. Collaborate with electronic medical record (EMR) providers on what fields to be built into the EMR to capture data for CLAS. Separate Alaska Natives from the Native American demographic; they have diverse needs and different healthcare providers.

Recommendations on Effective Communications Tactics/Channels to Educate Health Care Professionals About the CLAS Standards Toolkit: Introduce the toolkit as a framework for implementing and monitoring best practices on health equity and disparities or social detriments, with specific patient communications tools added. Include templates, policies, and procedures in the toolkit, and ensure a legal review for compliance with state regulations. Create a CLAS certification or assessment for employees, allowing them to display their competency in the area through a credential.

Lunch

Dr. Margot Savoy, *APOE Chair*

Dr. Savoy announced that the meeting would recess from 12:03 p.m. (EDT) until 1:00 p.m. (EDT), after which the meeting was reconvened.

Increasing Access, Quality, and Equity in Postpartum Care in Medicaid and CHIP: A Toolkit for States

Kristen Zycherman, RSN, BSN, *Maternal and Infant Health Initiative Lead, Center for Medicaid and CHIP Services (CMCS) Children and Adult Health Program Group*

Ms. Zycherman provided background information on the CMS Maternal and Infant Health Initiative (MIHI). MIHI launched in 2014 to improve access to and quality of care for pregnant and postpartum persons and their infants. MIHI focused on increasing the use and quality of postpartum care visits, increasing the service and quality of infant well-child visits, and decreasing the rate of cesarean births in low-risk pregnancies.

Ms. Zycherman presented postpartum care equity statistics. Women enrolled in Medicaid are more likely to be overweight or obese, smoke during pregnancy, and have chronic diseases than uninsured and privately insured women. Women of color and low-income women have the highest rates of postpartum depression. Women with public insurance have lower breastfeeding rates than women with private insurance. Based on a survey of 39 states, a median of 72% of women delivering a live birth had a postpartum care visit on or between 7 and 84 days after delivery.

Ms. Zycherman stated that CMS launched a Postpartum Care Learning Collaborative, starting with a three-part online seminar series and an action-oriented affinity group supporting nine state Medicaid and CHIP programs and their partners in designing and implementing data-driven quality improvement projects to improve postpartum care. Recordings of the online seminar series can be accessed at https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health/quality-improvement/postpartum-care/index.html. The nine participating states in the affinity group are Kansas, Texas, Oklahoma, Wyoming, Missouri, Kentucky, South Carolina, Montana, and Georgia.

Ms. Zycherman concluded by sharing information on a toolkit that CMS developed for state Medicaid and CHIP agencies to maximize the use of existing authorities to increase postpartum care access, quality, and equity for Medicaid and CHIP beneficiaries. The toolkit provides best practices to states, including strategies to support postpartum beneficiary engagement and communication with health care teams (e.g., language and translation services, doula, home visiting, transportation, and managed care and provider contracting); strategies to improve the quality of postpartum care (e.g., delivery system and payment models, lactation services coverage, smoking cessation coverage, contraceptive care, and postpartum depression screening, referral, and treatment); and strategies to measure and improve postpartum care access, quality, and equity through quality measurement and quality improvement.

Upon the conclusion of the presentation, Dr. Savoy opened the floor for questions.

Question 1: Is the toolkit only for state Medicaid and CHIP agencies?

CMS Response: While they are the target audience, the toolkit is publicly available on our website.

Discussion of Recommendations Among APOE Members and Ms. Zycherman

Recommendations for Promoting and Disseminating the Toolkit: The toolkit should be disseminated where people live, work, pray, play, and shop. Try tying the toolkit into other birthing and postpartum campaigns. Promote the toolkit to public health and state associations as well as family medicine physicians and hospital associations nationwide. Communicate with Women, Infants, and Children (WIC) and Supplemental Nutrition Assistance Program (SNAP) providers, who can connect with state officials to advocate for changes that can be made in their state's Medicaid and CHIP programs.

Alternate Formats of the Toolkit CMS Should Consider Developing: Consider developing an interactive and responsive website with dropdowns or creating videos (including short clips) or fact sheets. Use other digital platforms for the toolkit to be more user-friendly and easily accessible. Use clickable features to make the information more attention-grabbing and engaging.

Recommendations on Other Resources CMS Should Consider Developing: Consider developing a mobile app for the toolkit or providing information to states so they can create their own apps. Despite funding limitations, creating an app can be beneficial for increasing user interaction and engagement. Because the toolkit's primary audience is state Medicaid offices, develop parallel versions for alternative audiences, such as public health agencies, the public, or the birthing parent's partner or spouse. Consider an initial assessment or gap analysis that a state can complete regarding its current Medicaid offerings for postpartum care.

Listening Session: Medicaid and CHIP Redetermination and Renewals—Preventing Consumer Scams

Stefanie Costello, *Director, Partner Relations, OC, CMS*

Ms. Costello explained that the Medicaid and CHIP programs began redetermining eligibility for every enrollee in April. While states and CMS are conducting outreach to enrollees over the coming months, scammers might also take advantage and pretend to be a legitimate government agency to attempt to steal money or valuable information from customers.

Upon the presentation's conclusion, Dr. Savoy opened the floor for questions, but there were none.

Discussion of Recommendations Among APOE Members and Ms. Costello

What CMS Should Be Aware of Regarding Potential Scams Related to Medicaid or CHIP Renewals: Medicaid recipients in Pennsylvania have been receiving text messages asking for personally identifiable information, such as passwords, ID numbers, etc. There are fraudulent Facebook advertisements in Maryland and in rural communities in Texas and Arizona.

Differences CMS Should Be Aware of for Potential Scams Targeting the Medicaid and CHIP Population: Enrollment Assistance Programs could be perceived as frauds if they are not partnered with authoritative groups. There could be an influx of advertising from companies that sell short-term plans. While there may not technically be fraud, there could be negative financial implications for enrollees. This population may be more prone to text than phone call frauds. Frauds may be targeted as threats to undocumented individuals (e.g., you need to pay us, or we will tell the government about your status). If a state made a new enrollment portal, scammers might take advantage and create a lookalike portal that collects enrollee information.

Recommendations on Ways to Reach Medicaid and CHIP Beneficiaries to Warn Them of Potential Scams and How to Avoid Them: Pre-print addresses and phone numbers of the government agency receiving paperwork to add authenticity to the documents. Determine at which point a fraud is seeking money or data so that you can base your education on addressing how the government will not need that money or data. Give people verification mechanisms (e.g., a verification hotline or the ability to request information by mail on letterhead if someone feels uncomfortable). Create a single hotline for reporting frauds that can make investigative referrals for both state and federal violations.

Public Comment

Dr. Margot Savoy, *APOE Chair*

Dr. Savoy opened the floor for public comment, but no members of the public attended the meeting to provide comment.

Final Comments

Dr. Margot Savoy, *APOE Chair*

Dr. Savoy thanked all APOE members for their comments and input. She told APOE members that what they say matters: she has seen improvement in CMS materials based on previous APOE input. Dr. Savoy passed on a message from Vice Chair Cheri Lattimer, sharing that she enjoyed her time with APOE as well. Finally, Dr. Savoy thanked the staff for their assistance in implementing APOE meetings.

Meeting Adjournment

Walter Gutowski, *Acting DFO, Senior Advisor, Partner Relations, OC, CMS*

Mr. Gutowski stated that working with Dr. Savoy was a pleasure and thanked her for her service to APOE. He also said it was a pleasure meeting the majority of APOE members in-person for the first time. Mr. Gutowski adjourned the meeting at 2:45 p.m. (EDT). The next meeting of APOE will be announced in the Federal Register.