

**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, Room 738G  
Washington, DC 20201  
Monday, December 15, 2014**

**EXECUTIVE SUMMARY**

**Opening**

*Kirsten Knutson, Designated Federal Official, Office of Communications (OC), CMS*

Ms. Knutson called the meeting to order at 8:37 a.m. EST. She welcomed participants and noted that several new APOE members joined the panel and were at the meeting, three in person and one on the phone.

**Welcome and Introduction**

*Miriam Mobley-Smith, Pharm.D., APOE chair*

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

Dr. Mobley-Smith welcomed panelists, visitors, and federal employees who were present. She said she was looking forward to working with the new members and was honored to serve as APOE chair. She noted that Ms. Butler has been with CMS for 23 years. She welcomed Marjorie Cadogan to the role of APOE co-chair.

The September 2014 APOE meeting was canceled because the planned presenters were not available. Dr. Mobley-Smith said that APOE will try to plan further in advance in the future and adhere to quarterly meetings.

Panelists introduced themselves. Kellan Baker, a new panelist, and Joseph Baker, joined the meeting by phone.

Ms. Butler administered an oath to the new panelists and swore them in as APOE members.

**Recap of May 22, 2014 Meeting; CMS Response to APOE Recommendations**

*Dr. Mobley-Smith*

*Ms. Butler*

Dr. Mobley-Smith reviewed the topics from the May APOE meeting, and Ms. Butler presented CMS' responses to the recommendations from that meeting.

**Lessons learned from the inaugural launch of the Affordable Care Act (ACA) Marketplace:**

APOE made six recommendations to further the goal of program improvements for open enrollment in year 2 based on lessons learned. The first recommendation was to share data with key stakeholders including information about individuals who started but did not complete

enrollment; identify those who needed help with the process and why; delineate strategies for non-English speakers; and identify whether coverage has been maintained since enrollment and if not, why. CMS agreed with the recommendation and began sharing data before the beginning of the current open enrollment period. CMS has been reaching out to those who need assistance, particularly those with financial questions and immigration issues. The agency has begun releasing data weekly (rather than monthly) to stakeholders, partners, and others who are eager to assist those seeking coverage.

The second recommendation was to continue use of consumer testimonials to communicate messages and success stories about services. Ms. Butler said CMS accepts this recommendation and is planning testimonials from enrollees. OC will work with partners, navigators, assisters, and others to gather testimonials about the importance and benefits of coverage. Ms. Butler said CMS hopes that APOE panelists with close community ties will help gather testimonials.

The third recommendation was to coordinate media strategies by notifying assisters and Champions when the media will run ads so they can complement CMS media efforts. Ms. Butler said CMS will continue to notify all Marketplace partners when press releases, notifications, and social media messages are forthcoming.

The fourth recommendation was to partner with universities to increase student Marketplace enrollment. The CMS Partner Relations Group is currently developing a partnership with universities and anticipates that the strategy will be available in 2015.

The fifth recommendation was to determine whether assisters need improved training and develop a hotline for assisters to provide direct access to expertise. The CMS Center for Consumer Information and Insurance Oversight (CCIIO) solicited feedback from assisters, who said there is a need for a dedicated assister call-in line, something not currently available. CMS will establish an assister health resource center (AHRC) that will be available to a subset of assisters. AHRC will have a dedicated 800 line for questions and guidance that cannot be resolved otherwise. Because of budget restraints, it will not be available initially to all assisters. CMS will implement AHRC cautiously, so that it does not create another place for backlog.

The sixth recommendation for this topic was to improve the call center tier system to provide better support for complicated cases. Ms. Butler said a tiered system is now being rolled out for the Marketplace, but the number of agents is limited. She did not have specific information but said she would provide APOE more details about the system.

Coverage to Care pilot program to connect the newly insured to the health care system: Coverage to Care helps newly insured individuals find providers, seek services, and understand the importance of wellness and disease prevention. APOE made five recommendations. The first was to coordinate outreach and education activities with other programs such as Million Hearts®, Medicare Advantage, unemployment offices, local health departments, social service organizations, and others; provide more integration with state Medicaid and Children's Health Insurance Program (CHIP) plans; and customize materials for those aging into Medicare. CMS agreed with the recommendation and has worked with a myriad of community partners to reach as many consumers as possible as Coverage to Care moves from the pilot to national expansion.

The second recommendation was to continue developing in-depth and accessible training for assisters about how to use health insurance with a self-guided interactive online tool and video vignettes. CMS agreed with the recommendation and developed video vignettes during the pilot; the vignettes were translated into Spanish for the launch. CMS also developed a training module for assisters and will continue to gather feedback about possible additional tools.

The third recommendation was to explore why people could not access care, using data from the initial enrollment process. Ms. Butler said CMS disagreed with this recommendation. It is important to monitor access but not feasible to answer questions based on the original application process. CMS will consider other ways to evaluate access to care.

The fourth recommendation was to design a phone app for Coverage to Care and reach out to phone service carriers to facilitate readily available information. CMS agreed with the recommendation and will continue to develop additional tools, including apps, to help consumers and assisters.

The fifth recommendation for this topic was to extend Medicaid match grant program partnerships to other local entities. CMS agreed that it is vital for new enrollees to have the help they need to understand how to use their new health insurance benefits effectively. States may claim 50 percent matching funds and engage providers and community-based organizations in these efforts, with enhanced matching rates available for translation services.

Medicare preventive services and differences in coverage when transitioning to Medicare: There is confusion about preventive services and a need for effective communication with providers, beneficiaries, and their families. APOE made six recommendations. The first recommendation was for OC to develop a rapid response strategy to address erroneous and/or potentially misleading information. CMS agreed with the recommendation and will consider existing resources within the OC that can be modified to address this.

The second recommendation was to begin an education campaign with members of the press and build rapport with experts. CMS partially agreed with the recommendation. The OC routinely communicates with the press, and existing channels might be sufficient with experts.

The third recommendation was to bundle the Medicare annual wellness visit with other Medicare-covered services to enhance value and help providers understand how it works. CMS partially agreed. The visit is established by statute, and might be difficult to bundle with other services. To avoid the need for future visits, action on findings during the visit could be billable.

The fourth recommendation was to enlist partner organizations to help with information dissemination and reinforce communication about the importance of the medical home. CMS agreed with the recommendation. Coverage decisions often include accompanying educational materials.

The fifth recommendation was to collect and benchmark successful patient education strategies used by state-based Medicaid programs. CMS partially agreed. Ms. Butler noted that Medicaid strategies might not be generalizable to Medicare but could provide insight.

The sixth recommendation was to review and address the needed synchronization between the guidelines of the U.S. Preventive Services Task Force and congressional mandates for Medicare. CMS agreed and strives to be consistent with the Task Force, but exact synchronization might not be possible.

In a discussion of the previous recommendations, panelists asked for clarification about language, specifically, the exact differences between “agrees,” “accepts,” “partially agrees,” and “rejects,” and how CMS responds to recommendations.

### **Marketplace: Income Tax Time Communications**

*Julie Franklin, Director, Integrated Communications Management Staff, OC, CMS*

This is the first year that ACA Marketplace consumers will be asked to reconcile their tax obligations and perhaps pay a penalty. Many will not expect the penalty and might not understand how health insurance relates to taxes. CMS is working with the Internal Revenue Service (IRS) to ensure a consistent message to consumers about tax obligations. Different messages will be tailored for the 6 million consumers who have Marketplace coverage and those who have coverage from their employees, who received an exemption on the Marketplace, and who have no health insurance coverage.

Marketplace enrollees are required to fill out a Form 1095-A, which will provide coverage information to determine any credit due or tax owed. Fact sheets about the 1095-A will be posted on [healthcare.gov](http://healthcare.gov). Other communications will come through direct mail and social media, and assisters and the tax preparation community will be trained to help consumers. The IRS website contains materials with varying scenarios that are relevant to the different groups. CMS will conduct training for partners, and public education will begin in early January 2015.

Panelists suggested a number of venues for consumer education about tax implications of health insurance including community health centers, free clinics, faith-based organizations, insurance plans, tax preparers, university officials, and financial advisers. Other suggestions were to use the resources of AARP and other organizations and to include explanatory information with W-2 forms. Financial literacy organizations could educate uninsured individuals.

### **Recommendations for Marketplace Tax Communications**

Recommendations included simple messaging that it is time to settle tax obligations and that some might be eligible for an exemption. Social media can be used, and direct mail might also be useful. Tax preparers are an important point of contact. CMS should think about the right gatekeepers to reach different audiences. The press is an important stakeholder. Also, tax communications can provide teachable moments to look ahead to 2015 insurance enrollment. An add-on fact sheet with W-2 forms might be useful. CMS can use evaluations to develop refined ways of messaging and accumulate best practices for next year. A broad range of organizations

can disseminate the information, including state departments of taxation. Vignettes can be useful, and questions and experiences of same-sex couples should be considered.

### **Quality Improvement Innovation Models**

*Dennis Wagner, Acting Director, Quality Improvement Group  
Director, Quality Improvement Innovation Models Testing Group  
Center for Clinical Standards and Quality, CMS*

The CMS program features three quality improvement models: Quality Improvement Organizations (QIOs), the Partnership for Patients, and the Transforming Clinical Practice Initiative.

Sylvia Burwell, secretary of the Department of Health and Human Services (HHS), has released data about patient safety and emphasized four important changes from 2010 to 2013: a 17 percent reduction in hospital-acquired conditions (HACs), from 145 to 121 per 1,000 discharges; an estimated \$12 billion in associated cost savings; 50,000 lives saved; and 1.3 million harms prevented.

The QIO is dedicated to improving health quality at lower costs for Medicare beneficiaries. It is beginning work on its 11th statement of work, which moves from beneficiary and family-centered care to a Quality Innovation Network (QIN). The QIN will champion local, results-oriented change; facilitate learning and action networks; teach and advise technical experts; and communicate effectively. One of the tasks focuses on better care such as reducing care-associated infections and HACs and coordinating care to reduce readmissions and adverse drug events. Reducing catheter use has contributed to reducing health care-acquired infections. Families are an important part of the focus of QIO initiatives.

As specified by the ACA, the purpose of the Innovation Center is to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing quality of care from Medicare, Medicaid, and CHIP in an expedited process. There are many models in the field. The Innovation Center is focused on implementing models, monitoring and optimizing results, evaluation and scaling, integrating innovation across CMS, and portfolio analysis and launch of new models.

The practice transformation initiative begins by aligning as many federal and state programs as possible. Second, it funds practice transformation networks to improve practices and transition to alternate funding models. Third, support and alignment networks align with medical education, maintenance of certification, and other efforts. The goal is to support more than 150,000 clinicians in practice transformation and improve health outcomes for millions of Medicare, Medicaid, and CHIP patients, reducing unnecessary hospitalizations and generating billions of dollars in savings. An evidence base will be built for sustainability.

Funding announcements have been posted for the practice transformation network and a support and alignment network.

Partnership for Patients has the aims of a 40 percent reduction in preventable HAC and a 20 percent reduction in 30-day readmissions, with 11 core areas of focus for prevention. A range of private and public partners have aligned to work with the program. For example, the American Congress of Obstetricians and Gynecologists is working with the partnership to reduce the number of early elective deliveries, with large reductions documented. There is evidence for decreased rates of all core areas of harms.

In discussion, panelists raised questions about communications, data collection, engaging patients and families in the programs, and other topics.

### **Recommendations for Quality Improvement Innovation Models**

APOE panelists recommended development of a long-term roadmap for quality measures, working with existing programs, devising communications plans that use communications and quality improvement experts, actively engaging health plans and employers, and recognizing that focused activities and targeted outcomes can be more successful than a broader approach.

### **Overview of Proposed 2016 Payment Notice**

*Lisa Wilson, Senior Advisor, CCIIO, CMS*

CCIIO coordinates private insurance provisions of the ACA. The comment period for a new rule about payment and cost-sharing parameters closes on December 22, 2014. An important part of the ACA is to require insurers to post their rates, and part of the proposed rule is review on the plan level. Another proposal looks to increase transparency by having insurers post rates at a certain date.

CCIIO also is proposing changing dates of open enrollment. It is seeking comments on eligibility redeterminations, alternative re-enrollments triggered by circumstances such as rate increase, special enrollments, eligibility for exemptions, and establishing a process for reporting a death. Other topics covered by the new rule are essential health benefits benchmarks, standards for coverage of prescription drugs, network adequacy, paperwork reduction, limits for habilitative services, potential discriminatory practices, and clarification about community providers.

APOE members commented on the proposed rule, but did not formulate formal recommendations because of the limited timeframe for action. They asked about guidance on tax obligations, timing guidelines for publishing rates, re-enrollment, overlay of rules from one system to another, standards for essential community providers, clarification about deductibles, access to prescription drugs through mail order or community pharmacies, and implications of the ACA for same-sex couples.

## **Office of Inspector General (OIG) Beneficiary Complicit Fraud Prevention Campaign**

*Julie Taitzman, Chief Medical Officer, HHS OIG*

*Janna Raudenbush, Public Affairs Specialist, HHS OIG*

*Jennifer Hutnich, Program Analyst, HHS OIG*

*Sheila Davis, HHS OIG*

The OIG provides oversight of Medicare and Medicaid, ensuring efficiency and quality in the programs. Most of the work focuses on fraud prevention such as sharing Medicare or Medicaid numbers with non-eligible relatives or friends and providing unnecessary services, with Medicare fraud strike forces on a larger scale.

OIG has designed a series of posters targeting varying aspects of Medicare fraud. The aim is a culturally competent education campaign, tailored to specific groups to increase awareness among beneficiaries about the harmful implications of giving their Medicare number to fraudsters and decrease beneficiary involvement in fraudulent schemes. The posters make the point that Medicare fraud harms individuals and the community, and harms can range from denied medical service to identity theft to prison time.

OIG presenters reviewed five proposed posters and solicited feedback from panelists. The posters are based on actual occurrences such as a promise of free cable TV in exchange for a Medicare number. A telephone number, website, and quick response code are in the bottom corner of each poster to allow fraud reporting. Other posters depict a perpetrator of fraud in an orange prison jumpsuit, a “helpful friend” as a “criminal in disguise,” cash as bait for a Medicare number, and a “gift” that results from sharing a Medicare number.

In general, panelists were critical of the posters, questioning whether the ideas were clearly conveyed and understandable. Other points were lack of an overarching theme for the campaign and an overly broad focus of the individual posters, although too much specificity also can be a problem. Panelists recommended getting feedback from focus groups and using professional marketers to create the messages and designs and avoid mixed messages. Another suggestion was to warn early Medicare recipients of the dangers of fraud when they receive their cards. Other stakeholders (e.g., AARP and physician groups) also could be valuable consultants. It is important to be aware of the implications of some messages (such as an accusatory tone) in non-English speakers and immigrant communities. Different messages are needed for criminals and unsuspecting accomplices.

## **Recommendations for OIG Fraud Prevention Campaign**

APOE panelists recommended that OIG seek professional advertising and marketing consultation for its anti-fraud media campaign, communicate the possibility of fraud to beneficiaries as they first receive their benefits, and focus on one or two messages. An important focus is “consumer beware.” Other recommendations included: use focus groups to test the messages, partner with organizations that have successfully implemented these types of campaigns, develop vignettes to illustrate the scenarios, and concentrate on a target market where certain scams are occurring. Also, do not alienate legitimate beneficiaries who might be

susceptible to fraud efforts and collaborate with other CMS offices that might have some experience in this area.

### **Public Comment**

There were no public comments.

### **Recap of Meeting and Final Comments**

*Marjorie Cadogan, APOE co-chair*

Ms. Cadogan thanked the chair and panelists for their discussion and recommendations. The task now is to formalize and organize the suggestions into topic areas so that they can become actual recommendations.

Dr. Mobley-Smith welcomed the new panel members and thanked them for their contributions.

### **Adjournment**

Ms. Knutson said the next meeting will be in March 2015 in the same building. She adjourned the meeting at 3:36 p.m. EST.