

**Meeting of the Advisory Panel on Medicare Education (APME)
Centers for Medicare & Medicaid Services (CMS)
March 31, 2010
Hilton Washington Hotel Embassy Row
Washington, D.C. 20036**

Location:

The meeting was held at the Hilton Washington Hotel Embassy Row, 2015 Massachusetts Avenue, NW, Washington, D.C. 20036.

Panel Members Present:

Gwendolyn T. Bronson, SHINE/SHIP Counselor, Massachusetts SHINE Program

Yanira Cruz, Ph.D., President and Chief Executive Officer, National Hispanic Council on Aging

Stephen P. Fera, M.B.A., Vice President, Social Mission Programs, Independence Blue Cross

Nan-Kirsten Forté, Executive Vice President, Consumer Services, WebMD

Richard C. Frank, M.D., Director, Cancer Research, Whittingham Cancer Center

Cathy C. Graeff, R.Ph., M.B.A., Partner, Sonora Advisory Group

Carmen R. Green, M.D., Professor, Anesthesiology and Associate Professor, Health, Management, and Policy, University of Michigan

Jessie C. Gruman, Ph.D., President, Center for Advancing Health

Cindy Hounsell, J.D., President, Women's Institute for a Secure Retirement

Kathy Hughes, Vice Chairwoman, Oneida Nation

Gail Hunt, President and Chief Executive Officer, National Alliance for Caregiving

Warren Jones, M.D., F.A.A.F.P., Executive Director, Mississippi Institute for Improvement of Geographic Minority Health

Sandy Markwood, Chief Executive Officer, National Association of Area Agencies on Aging

David W. Roberts, M.P.A., Vice President, Government Relations, Healthcare Information and Management System Society

Julie Bodén Schmidt, M.S., Associate Vice President, Training and Technical Assistance, National Association of Community Health Centers

Rebecca P. Snead, Chief Executive Officer and Executive Vice President, National Alliance of State Pharmacy Associations and APME Chair

Donna Yee, Ph.D., Chief Executive Officer, Asian Community Center of Sacramento Valley

Panel Members Absent:

Deeanna Jang, Policy Director, Asian and Pacific Islander American Health Forum

Andrew Kramer, M.D., Professor of Medicine, Division of Health Care Policy and Research, University of Colorado, Denver

John Lui, Ph.D., M.B.A., Executive Director, Stout Vocational Rehabilitation Institute

Open Meeting

Cindy Falconi, Acting Designated Federal Official, Office of External Affairs (OEA), Centers for Medicare & Medicaid Services (CMS)

Ms. Cindy Falconi called the meeting to order. In compliance with a White House directive, she confirmed that there were no lobbyists in attendance. Additionally, she announced that the public would have an opportunity to offer comments at 2:40 p.m.

Welcome and Introductions, Swearing in of New Members, and Review of Previous Meeting

Rebecca Snead, APME Chair

Teresa Niño, Director, OEA, CMS

Ms. Falconi asked each of the three new Advisory Panel on Medicare Education (APME) panelists to swear the oath of office. Taking the oath were:

- Richard C. Frank, M.D., Director, Cancer Research, Whittingham Cancer Center;
- Warren Jones, M.D., F.A.A.F.P., Executive Director, Mississippi Institute for Improvement of Geographic Minority Health; and,
- Donna Yee, Ph.D., Chief Executive Officer, Asian Community Center of Sacramento Valley.

Ms. Rebecca Snead welcomed all of the panel members and asked each of them to introduce themselves. Following the introductions, Ms. Snead briefly summarized the content of the last APME meeting, which took place in October 2009. Topics discussed during the meeting were the Medicare Options Compare tool; Durable Medical Equipment, Prosthetics, and Supplies (DMEPOS) competitive bidding process; Hospital Compare composites; and faith-based and community outreach. The panel subsequently provided CMS with a list of questions and recommendations resulting from its discussions on these matters as well as a list of topics the members would like to see addressed in future meetings.

Ms. Teresa Niño also welcomed the panelists, especially those who had just joined the group. She highlighted some of the features of the recently passed health care reform package, including helping children with pre-existing conditions and allowing children to stay on their parents' policies until age 26. She informed participants of important additions to the CMS leadership team including Peter Budetti, M.D., Deputy Administrator, Center for Program Integrity, and Anthony Rodgers, M.S.P.H., Deputy Administrator for Strategic Planning.

Listening Session with CMS Leadership

Charlene Frizzera, Acting Administrator, CMS

Ms. Niño introduced Ms. Charlene Frizzera and briefly reviewed her career at CMS. Ms. Frizzera expressed her excitement over being able to meet with the APME at this time of great energy and activity surrounding health care. She began the discussion with a summary of the issues brought to CMS by the APME during her tenure as Acting Administrator.

Of all of the recommendations made by the panel, CMS did not implement the following three:

- Medicare Integrated Tool – CMS has not incorporated drug-to-drug interaction information due to concerns over beneficiary education. CMS is concerned that beneficiaries will misunderstand the information or make incorrect assumptions if the tool only includes a list. Therefore, it is looking into ways to help beneficiaries be able to find this information for themselves. CMS also hopes that use of electronic health records (EHRs) by providers will help reduce the likelihood of beneficiaries experiencing an interaction.
- DMEPOS Information Via the Hotline – In response to the long waits experienced by beneficiaries calling the 1-800-MEDICARE hotline for information on DMEPOS coverage and suppliers, the panel suggested a call back function to reduce wait times. CMS has developed a speedier way for beneficiaries to get this information through the hotline by referring callers to a customer service representative with expertise in this area. Callers are now getting their calls answered in a matter of seconds.
- DMEPOS Covered Equipment – CMS will work to educate beneficiaries about the 10 items covered by DMEPOS in Round 2 (a smaller list of items was covered in Round 1), with an emphasis on the choices available to beneficiaries.

Next, Ms. Frizzera reviewed the APME recommendations on which CMS has taken action:

- Redesign of the Medicare Options Compare Tool for 2010 – The updated tool will remind beneficiaries to update their drug lists and review their drugs with their physicians. Additionally, sorting and filtering features for dental and vision options will be featured more prominently.
- DMEPOS – CMS has tested beneficiary messaging, including messages on supplier accreditation, where to go for supplies, what to do if a current supplier will not participate in the program, and where to go for help. CMS is developing a factsheet explaining the competitive bidding process for partners and interested parties that includes links to additional information.
- Hospital Compare Composites Outpatient Safety Quality Measures – CMS is improving its explanations of inpatient and outpatient hospital services, especially in terms of payment and obligations. Of particular concern are the differences between outpatient observation days and inpatient services and how these translate into patient financial responsibilities.
- Quality Measures – CMS is revising its beneficiary-targeted publication on the use of quality measures in the health care decision-making process. The emphasis is on what measures can and cannot tell beneficiaries and how they should be used in conjunction with other information (e.g., star ratings, etc.).
- Faith-Based and Community-Based Outreach – CMS is aligning partners around specific initiatives such as the Child Health Insurance Program and the low-income subsidy to address immediate needs.
- Limited English Proficiency Toolkit – CMS has developed a toolkit to help partners work with those with limited English skills.
- Catalog of Partners – CMS is developing a catalogue of partners, organized by sector, to help with targeted outreach. This will help partners connect with each other as well as help those looking for assistance for beneficiaries.

CMS is very excited about the opportunities to improve delivery of services to beneficiaries presented by health care reform. The agency will apply lessons learned during the Part D implementation to reform activities, particularly with regard to using partners and beneficiary feedback to identify problems and improve systems throughout the rollout period. It will be essential to listen to beneficiaries, as they are the agency's best resource when it comes to figuring out their needs and identifying problems in the system. The initial set of implementation due dates occur in July 2010, but CMS is aggressively working to meet the requirements before the respective deadlines.

Ms. Frizzera concluded her opening remarks by indicating that she anticipated that a new CMS Administrator would be named soon, making this meeting her last as Acting Administrator. Ms. Snead thanked her for all of the time and attentiveness she devoted to the APME panel over the course of her tenure.

Member Comment – Ms. Gail Hunt noted that hospitals are placing some patients in an effectively “permanent” observation status to avoid admitting them and risking a subsequent readmission within 30 days. She suggested that CMS look into this matter to determine how frequently this occurs.

Member Comment – Ms. Gwendolyn Bronson observed that there is an occasional disparity between the drug costs listed on the prescription drug tool and the actual costs charged to the beneficiary. She asked if CMS could explain to beneficiaries why this happens.

CMS Response – Ms. Frizzera replied that CMS has heard this complaint before. She promised to report back on the reasons this occurs. Later in the session, Ms. Frizzera was able to report that the discrepancy usually results from differences between the listed and prescribed quantity or dosage. The website is updated bi-weekly, which could also account for some discrepancies. She stressed the importance of reporting any discrepancies so that CMS can determine why they are occurring.

Member Comment – Dr. Yee stressed the importance of educating beneficiaries about the nature of their hospital stays (acute versus observational). She also pointed out that observational stays often result in a lack of discharge planning, especially for those who need skilled nursing.

CMS Response – Ms. Frizzera asked panelists to send examples of problems associated with observational stays to CMS as specific examples help pinpoint problems and support the development of solutions.

Member Comment – Mr. David Roberts pointed out that providers bear an ever-increasing burden related to reporting requirements (50-10, International Classification of Diseases[ICD]-10, e-prescribing incentives, EHR incentives, quality metrics reporting, etc.). He suggested that the APME devote a full meeting to addressing ways to support providers as they struggle to meet these requirements and ensure that they report all of the information that is required.

CMS Response – Ms. Frizzera noted that health reform provides an opportunity to revisit issues – such as administrative simplification, quality, and improved reimbursement policies – and to

focus on physicians and the burdens CMS places on them. Mr. Rodgers added that the vision of widespread adoption of EHRs is central to the goal of transforming health care delivery. He expressed hope that the APME would help CMS develop strategies to support physicians who are struggling through the implementation phase. Additionally, the Center for Innovation and Strategic Planning is working to optimize the use of EHRs to simplify processes within the doctors' office, improve quality, reduce costs, and engage beneficiaries. The Office of the National Coordinator will play an important role in helping physicians through this adoption period.

Member Comment – Dr. Carmen Green raised concerns about the timing and content of communications about health care reform, as many elders do not know what it includes. This provides an opportunity to engage beneficiaries and elders in a conversation. CMS should develop one-page briefing sheets addressing reform as it affects elders, minority populations, children, and those with disabilities. This would help panel members and other partners explain reform to their constituencies. She was especially concerned that the APME will not meet again until after messages have been developed and disseminated.

CMS Response – Ms. Frizzera agreed that CMS needs to have public information on reform. There are three phases to any education campaign – awareness, education, and use. Currently, CMS is working on the awareness phase. She committed to sharing any information CMS develops for each of these three phases for APME review and comment. She also asked the panel to send in their ideas for the education phase. She did not think that it would be possible to reconvene the panel prior to the next scheduled meeting.

Member Comment – Dr. Green was also concerned that misperceptions and miscommunications could get ahead of the CMS information campaign (both for reform and for fraud prevention). She suggested a “pre-emptive strike” with regard to both awareness and education.

CMS Response – Ms. Niño pointed out that even small changes are helpful and important. She noted that CMS has recently changed its Medicare.gov website to indicate that Medicare is the official government-run program. CMS is aware that there will be much inaccurate information concerning reform and will work hard to dispel it. Ms. Frizzera pointed out that education efforts about health reform are much bigger than those associated with Medicare and Medicaid. Beneficiaries have many questions about reform. CMS needs to be thoughtful about the information it provides without being overwhelming. Education efforts need to address health reform in a general way as well as specifics related to Medicare and Medicaid.

Member Comment – Ms. Nan-Kirsten Forté suggested that CMS look back at the most successful elements of the Part D rollout as it plans its reform-related communications. She stressed the important role the APME panel played in the past as interpreters for their various audiences and constituencies. The panel can help drive people to the CMS website and information resources. CMS has not yet requested the assistance of the panel or provided goals and objectives for health reform activities.

CMS Response – Ms. Frizzera emphasized that CMS does not feel overwhelmed by all of the work involved with reform and is addressing the requirements and deadlines in a strategic way.

She also agreed that getting people to the website – and understanding who visited and for what purpose – is very important. The agency will develop goals, but anticipates that the goals will be more specific than during the Part D rollout. Finally, she noted that the designation of the Medicare website as the official government website will help clear up confusion created by other groups' use of the Medicare logo on their sites. She affirmed that CMS would look to the APME for suggestions and support during the coming months.

Member Comment – Ms. Forté noted that she was simply attempting to provide examples of ways the panel could magnify and amplify CMS' efforts.

Member Comment – Dr. Jones stressed the importance of always working toward that which is in the patient's best interest. He thanked CMS for acknowledging the dangers of a drug interaction list without the proper education concerning its use. Dr. Jones stressed the need for cultural proficiency in all communications and the importance of including it in physician training. It is important to engage physicians in the integration of technology into their practices. CMS can direct changes to make this happen. He also recommended the use of "just in time" messaging throughout the outreach and education campaign.

CMS Response – Ms. Frizzera noted that many of CMS' messages are about creating smarter doctors and smarter patients. The agency hopes that people will realize all of the benefits of EHRs. She also noted the important role physicians who are advocates of information technology can play in facilitating the adoption and full use of EHRs. Mr. Rodgers asked the panel for suggestions (e.g., education products) that will help beneficiaries and providers become comfortable in a virtual world. He suggested that practices have e-learning stations within the waiting room where patients can review their personal health records and learn more about health topics. Mr. Rodgers asked the panel to help CMS innovate the configuration of these tools and make them culturally competent, specifically with regard to new products that can be developed to support the agency's efforts.

Member Comment – Ms. Sandy Markwood reiterated the value of CMS' partnership network and of the need for just in time communications to partners (e.g., webinars) as they work to spread CMS messages to their constituencies.

CMS Response – Ms. Frizzera replied that CMS will definitely make extensive use of its partners in its communications efforts.

Member Comment – Dr. Frank expressed concerns about CMS' outreach to older individuals who are not web savvy and asked if CMS would communicate solely by Web or by more traditional methods as well.

CMS Response – Ms. Frizzera assured the panel that CMS will continue to send out print materials. The Social Security Administration has been, and continues to be, supportive of CMS' communications efforts. CMS will use many methods and its partner network to disseminate information.

Member Comment – Dr. Jessie Gruman pointed out that patients must still be responsible for sharing information from one of their providers with all of their other providers. Until EHRs are fully implemented and link providers, patients must continue to share information. CMS needs to remind beneficiaries that they must continue to do this.

Member Comment – Ms. Julie Bodën Schmidt noted the need to dispel beneficiaries' fears before CMS can effectively communicate its messages. Many beneficiaries are afraid of the electronic world and what happens to their personal information in it.

CMS Response – Ms. Frizzera agreed and stressed the importance of avoiding the use of words such as “fear” and “confusion.” The challenge is to make beneficiaries comfortable with EHRs. Physicians can play an important role in increasing patient comfort with EHRs by showing them how they work and explaining their benefits.

Member Comment – Ms. Hunt reminded participants that only one-quarter of current beneficiaries use the Internet. This underscores the need for a single-page, print brochure explaining reform. She also noted that in many cases, it is the family caregiver who reviews and responds to communications from CMS, especially in the case of beneficiaries with Alzheimer's disease.

Member Comment – Mr. Roberts noted that there are great concerns and misunderstandings about the security and privacy of EHRs (they are secure, but not private). CMS needs to address these concerns and explain how EHRs support the process of delivering health care.

CMS Response – Ms. Frizzera agreed and noted that CMS is trying to explain EHRs in terms of making doctors better at what they do.

Member Comment – Mr. Stephen Fera felt that there is a low level of connectivity between current ideas and the real world. With the erosion of Medicare Advantage, CMS will rely more on physicians to translate information for beneficiaries, placing additional burdens on them. He also noted that there are many challenges to transitioning the health care system into widespread use of technology.

CMS Response – Ms. Frizzera agreed that the transition period offers great challenges for both beneficiaries and providers. Generational expectations are very different, among both beneficiaries and doctors. She added that CMS' intention is not to squeeze managed care out of the market; instead, the goal is to make all programs work more efficiently.

Ms. Frizzera concluded her remarks by summarizing the list of items addressed during the discussion that need further action by CMS or the APME:

- CMS will look into the rehospitalization/observation days issue and develop educational pieces related to improving beneficiary understanding of inpatient/outpatient services in hospital settings. Additionally, discharge planning issues need to be addressed.
- CMS will inventory requirements that might be seen as burdensome to providers.
- CMS will develop one-page factsheets about reform for targeted audiences (including caregivers and providers).

- CMS will utilize the panel as interpreters for reform information. The agency will also share beneficiary education/communication goals and resulting products concerning reform with the panel.
- CMS will emphasize the benefits of EHRs with regard to the delivery of health care in its communications.

Ms. Snead stressed the willingness of the panel members to help amplify CMS' outreach efforts. She thanked Ms. Frizzera for the time and energy she brought to her work at CMS and with the APME.

Motivating Providers Towards EHR Adoption: The Impact of Consumers

Patty Helphenstine, Strategic Research and Campaign Management Group, OEA, CMS

Following the break, Ms. Falconi again asked if there were any lobbyists in attendance. None were present.

Ms. Patty Helphenstine, who oversees strategic outreach efforts concerning EHRs at CMS, directed panelists to the handouts, which included information on the CMS webpage detailing the Health Information Technology for Economic and Clinical Health regulations and related information.

She was pleased to see the general level of agreement concerning the important role EHRs will play in changing the way health care is delivered and ensuring that patients receive the best possible care at the point at which it is delivered.

The EHR incentive program is actually six separate programs. Eligible providers and hospitals can elect to participate in the Medicare, Medicaid, or Medicare Advantage incentive programs. Eligibility requirements vary. Outreach efforts for the incentive program need to reach all providers and hospitals. Beneficiaries need to understand the changes they see when they visit providers and hospitals that adopt EHRs. They also need to have their concerns over privacy and security addressed. Ms. Helphenstine asked the panelists for their recommendations concerning the types of outreach that should be employed, ways to leverage communications to engage and motivate providers and beneficiaries, and strategies to encourage providers to adopt EHRs. She asked the panelists to focus on provider outreach first, then move on to a discussion of beneficiary outreach.

Member Comment – Ms. Cathy Graeff asked whether Medicare or the Medicare Advantage plans administer the payment of the provider incentives. She also asked how the Medicaid incentives are paid.

CMS Response – Ms. Helphenstine replied that CMS pays the Medicare Advantage plans, which then administer the payment of the incentive funds to the providers. Medicaid incentives are a voluntary program at the state level. When states offer the incentive, they handle the payments to the providers.

Member Comment – Dr. Frank suggested that CMS share with the panel the March 15 letter concerning issues related to EHR adoption that was signed by all 48 state medical societies and 38 medical academic and medical specialty groups that was sent to Ms. Frizzera. It addressed operational issues and transitional needs that should be considered before the EHR program is begun. The signatories felt that the CMS criteria for achieving meaningful use of EHRs is too aggressive and may discourage practices from participating in the incentive program.

CMS Response – Ms. Helphenstine indicated that the comments would be publically available if they were submitted as official comments. CMS is reviewing all submitted comments, but she was unable to share any information on the options under consideration.

Member Comment – Mr. Roberts felt that starting with providers was a wise way to begin the outreach effort. Providers are required to implement ICD-10. E-prescribing is still challenging, even though there are incentives available. The EHR program is an additional layer on top of these existing requirements. Under the EHR incentives, providers and hospitals will have to report on 25 new metrics in Stage 1 (18 are self-reported measures, but the balance require the filing of actual metrics). The challenge is finding a middle ground for the Stage 1 requirements in order to attract as many participants as possible since the bulk of the incentives are available during this stage. Privacy issues and delivery of health care services need to be addressed. Consumer education will need to explain that EHRs are simply tools. Mr. Roberts concluded his remarks by pointing out that meaningful use requires the exchange of information, but the health information exchanges (HIEs) that make this possible are unfunded mandates for states. CMS needs to plan for the continuum of burdens that providers will face throughout the adoption process.

Member Comment – Dr. Frank added that providers will need feedback throughout the adoption process to ensure that they have fulfilled the requirements and implemented their systems in the proper way.

Member Comment – Ms. Snead underscored the importance of the inventory of burdens.

Member Comment – Ms. Bronson asked if the incentive funds would be available retrospectively, specifically for those practices that installed EHRs prior to the start of the incentive program.

CMS Response – Ms. Helphenstine clarified several aspects of the program. The program will begin in early January 2011 and will provide incentives for using EHRs in a meaningful way (not reimbursement for the purchase of a system). There are caps on the incentive amounts that can be claimed, and payments are spread out over a period of several years. The definition of meaningful use is very detailed but generally refers to reporting on how practices use EHRs and performance on quality measures.

Member Comment – Dr. Jones observed that physicians want to use EHRs to optimize the flow of their practices, but they have problems doing so in an era of increasing administrative burdens. If CMS can communicate to providers that it will find a way to lessen the administrative burden, they will listen. Lower administrative burdens will increase the time

physicians can spend with patients. He also pointed out that it is less expensive to sustain an HIE over time than it is to create a new one each time there is a pressing need (e.g., a hurricane causes an out migration). States need to take the lead on developing HIEs, which requires a functional EHR. He also suggested that CMS promote the long-term benefits of EHRs, including better documentation, more effective billing, better audit results, and increased revenue.

CMS Response – Ms. Helphenstine indicated her appreciation of the forward-looking nature of Dr. Jones' comments. CMS is hoping to emphasize motivators in its communications. It is important to keep the idea of compassionate care in the messaging as well as making the business case for adopting EHRs.

Member Comment – Ms. Graeff suggested that since EHRs are primarily an information technology project, CMS should target office staff. Town halls – repeated multiple times – can be very effective. The regional centers will play a very important role in helping practices, especially small practices, work through implementation challenges. CMS needs to increase awareness of the tools that will be available to help practices adopt EHRs. Early messages need to be consistent and centralized through CMS.

Member Comment – Dr. Green suggested that CMS focus its messages on the challenges faced by physicians as they try to adopt EHRs. Doctors are focused on providing good care; CMS needs to make EHRs relevant to providing this care. The move to EHRs means a move to a new business model that will affect all of the practice staff. It will be important to think about how having a computer in the exam room will affect communication with patients.

CMS Response – Ms. Helphenstine asked if Dr. Green was suggesting that CMS provide guidance on where computers should be located in patient settings.

Member Comment – Dr. Green replied that those types of issues have not yet been considered. Patients might feel that EHRs are distracting doctors from listening to their concerns. She suggested that CMS present models of good practices. Additionally, CMS needs to understand patients' expectations of EHRs.

CMS Response – Ms. Helphenstine agreed that CMS needs to consider the dual needs of both patients and providers.

Member Comment – Mr. Roberts noted that this is the only time providers will anything akin to an entitlement program for doing something specific. Providers need to take advantage of this one-time cost reimbursement. EHR manufacturers are changing their marketing to address the incentives. With regard to HIEs, Dr. Roberts pointed out the need to develop sustainable HIE models and funding streams. He felt that the CMS Regional Offices would have a large role in communicating CMS' messages concerning EHRs, especially in terms of arranging educational sessions.

Member Comment – Ms. Helphenstine expressed her interest in feedback on leveraging the inevitability of the program as well as identifying the motivators for early adoption.

Member Comment – Dr. Frank observed that the meaningful use issue is very significant. If physicians purchase and install an EHR but do not meet the meaningful use criteria, there will be significant drop-offs in participation. Cost is also an issue. CMS estimates that the average cost per physician for EHR adoption is \$54,000, and annual maintenance costs are approximately \$10,000. There should be a designated CMS point of contact for small practices to assist with adoption and meaningful use issues. He added that consumers/beneficiaries would form their opinions of EHRs based on their doctors' opinions. The average physician must ultimately come to believe that EHRs are working well.

Member Comment – Dr. Yee pointed out that doctors need to understand that EHRs can help them treat patients who have multiple return appointments or chronic condition management issues. She also pointed out that EHRs can help patients be more accountable by capturing information they might forget. EHRs can help physicians treat patients when they are traveling, make information available to physicians on the same system, make management of chronic conditions easier, and help caregivers assist those in their care manage their own care. CMS needs to promote to the general public the vision of what EHRs can do for patients and physicians.

Member Comment – Ms. Kathy Hughes, speaking from the rural and Native American community perspectives, pointed out that the EHR message has been received. It is generally acknowledged that EHRs will happen; the timing is just not certain. Consumers will go with whatever system their current providers adopt. She expressed concerns over the lack of technical and administrative capabilities and the lack of broadband access in rural communities. In some cases, having a personal EHR on a zip drive or implant might be more helpful to individual patients in certain situations. Ms. Hughes also noted that there is a lack of urgency among providers (they will make changes only when required to do so).

CMS Response – Ms. Helphenstine asked panelists to share their thoughts on the most effective motivators/influencers with regard to providers.

Member Comment – Dr. Frank suggested that state medical societies and specialty organizations are very influential.

CMS Response – Ms. Helphenstine asked to what degree peer-to-peer advocacy is effective.

Member Comment – Ms. Schmidt pointed out the need to find a “champion” provider to set an example and lead the way for other providers in a particular area. She also stressed the important role nursing staff can play in helping physicians adjust to and more readily adopt EHRs. It is also important to have an individual within each practice who is able to debug the system and resolve problems quickly to prevent the reinforcement of skepticism about the utility of EHRs.

Member Comment – Dr. Jones agreed with the ideas of targeting specialty societies and state medical and nursing organizations. He also suggested targeting nurse practitioners and physician assistants in rural areas. Dr. Jones noted that there will always be individuals who are never satisfied or who complain as part of their personalities. CMS will need to develop a way to separate legitimate problems from complaints flowing out of personality issues. CMS needs to

use its influence to focus the provider community on the steps needed to implement EHRs and to realize the greater benefits to the wider community.

Member Comment – Dr. Yanira Cruz noted the important of reaching out to consumers and focusing on the benefits that they will experience as a result of EHRs. CMS needs to work with local community leaders to disseminate consistent messages.

Member Comment – Mr. Roberts suggested that CMS highlight success stories early in the process. He also suggested that CMS start with underserved and minority communities because they will face the greatest difficulties in getting started and maintaining EHR systems.

Ms. Helphenstine asked panelists to shift their focus and share their thoughts on the most appropriate time to deliver consumer messages. She expressed concerns over the possibility of promising more than EHRs can deliver in the near term but hoped that it would be possible to educate consumers about the longer-term possibilities associated with EHRs.

Member Comment – Ms. Hunt pointed out that those who know about personal health records (PHRs) – some beneficiaries and possibly adult children or caregivers – want to know how they will interface with EHRs and whether the patient/caregiver will have the ability to input information into EHRs. It is important that the patients feel that the information in the EHR is available to them.

Member Comment – Ms. Forté indicated that the CMS e-prescribing brochure for patients that focused on benefits was a very good piece and could be a template for an EHR brochure. WebMD forwarded the information to its various audiences, and it was well received. She also pointed out that the larger issue is not how EHRs and PHRs interact, it is about improving the exchange of health care information. CMS should focus on benefits such as patients no longer having to remember details of their care and the improved quality of interactions with physicians.

Member Comment – Dr. Green noted that CMS should consider gender-specific communications, as women tend to be the caregivers. She also suggested that CMS consider the context of models for quality and efficiency, which do not address dual-eligibles and the underinsured. The agency should highlight safety net hospitals. With regard to privacy and security issues, Dr. Green noted that perceptions are valid until proven otherwise. A single loss of a computer with personal data makes people think it happens frequently; CMS will have to manage this sort of negative perception. By taking care of the most vulnerable and sensitive populations first, CMS can improve its overall communications with the wider audience.

Member Comment – Dr. Gruman agreed with sharing success stories related to EHRs. However, CMS needs to emphasize that patients are still responsible for making sure their information is shared between providers until there is an interoperable system in the United States. Even when the system is in place, CMS needs to stress the importance of patient responsibility with regard to both records and to overall health.

Member Comment – Mr. Roberts expressed his opinion that consumers are concerned about receiving good health care, not the tools their doctors use to ensure they receive it. Privacy and security issues are similar for both paper and electronic records. CMS should focus on provider education, as they will be the ones using EHRs on a daily basis. Consumers will adapt to new technologies and will ultimately prefer providers who use electronic records. He anticipated that electronic medical records will fuel consumer interest in PHRs.

Member Comment – Ms. Markwood favored the idea of using champions of EHRs and success stories. CMS needs to focus on the benefits of EHRs, including making things easier for patients and caregivers, increasing the accuracy and accountability of medical records, and better health outcomes. Beneficiaries who ask their providers about EHRs are advocates for EHRs. Generational differences should be taken into account when developing messages because different generations look at their responsibility for health care very differently.

Member Comment – Dr. Jones cautioned CMS to avoid incendiary or confrontational language in its messaging (e.g., entitlement). Many of the providers who take on new Medicare patients are losing their financial margins and CMS needs to communicate with them in a way that is supportive and shows appreciation for what they are doing.

Member Comment – Ms. Forté reiterated the importance of taking intergenerational differences into account when developing messages. Children, including adult children, can lead their parents to accepting EHRs. She also suggested that CMS create slide shows for specific groups that address the myths and misperceptions about EHRs.

Member Comment – Ms. Graeff observed that consumers do not know the difference between privacy and security, nor do they know about existing privacy and security laws.

Helping Consumers Identify and Combat Fraud

Lisa Vriezen, Deputy Director, Program Integrity Group, Office of Financial Management, CMS

Ms. Lisa Vriezen began by announcing that the Center for Program Integrity has a new director, Dr. Budetti. By elevating the program integrity function to center status, CMS has signaled an increased emphasis on fighting fraud. The Center is already working on writing regulations related to the recently passed health reform legislation.

Ms. Vriezen reviewed the slides presented during the March 25 pre-brief conference call. She identified and described four websites that provide information on identifying and reporting Medicare fraud. Although the Medicare Learning Network offers online educational information for providers, beneficiaries can also use it to find helpful fraud-related information. CMS also distributes several print publications on fraud.

Working with the Department of Justice, CMS developed the Health Care Fraud Prevention and Enforcement Action Team (HEAT), which shares information on investigations, data, and

cooperative activities. HEAT has a website, www.StopMedicareFraud.gov, designed to help beneficiaries report fraud and learn about fraud investigations in their areas.

Medicare number identity theft is an ongoing problem. CMS estimates that more than 100,000 Medicare numbers have been compromised. The agency will undertake a program to educate beneficiaries about protecting themselves against identity theft.

Ms. Vriezen also described the work of the seven Payment Safeguard Contractors (PSCs)/Zone Program Integrity Contractors. These contractors identify fraud through data analysis and identification of anomalous patterns of usage. CMS is working on an integrated data repository (Medicare and Medicaid claims data) that will help it identify patterns of fraud and allow the two programs to alert each other to fraud new schemes. Medicare tries to target resources in areas where fraud occurs most frequently. Currently, most fraud relates to home health and durable medical equipment (DME). CMS places much emphasis on identifying and following up on suspect suppliers as well as on monitoring geographic areas that have high supplier turnover.

Ms. Vriezen discussed the fraud resources available through the 1-800-MEDICARE hotline. Customer service representatives are now receiving more fraud-related training. Additionally, beneficiaries in Florida, where most fraud occurs, can call a hotline exclusively for their use. CMS is looking at installing hotlines in other areas of the country.

Additional tools to help beneficiaries identify fraud are the Medicare Summary Notices (MSNs), and the Senior Medicare Patrol (SMP). CMS sends beneficiaries MSNs each quarter (Florida beneficiaries receive their MSNs on a monthly basis). The MSNs list all services billed for each beneficiary and the provider's name and location. By reviewing the MSNs on a regular basis, beneficiaries and caregivers can identify services they did not receive but for which Medicare was billed. CMS works with the Administration on Aging (AoA) to sponsor the SMP, which consists of retired individuals who are trained to go out into the community and educate seniors about Medicare programs. The SMP, which operates in all 50 states, helps to educate beneficiaries about fraud and reports instances of suspected fraud for further investigation.

Ms. Vriezen concluded her remarks by asking panelists to provide any suggestions they might have to help CMS better communicate with and educate beneficiaries about fraud.

Member Comment – Dr. Roberts asked if expenditures on Medicare's fraud fighting efforts are capped by Congress.

CMS Response – Ms. Vriezen noted that Medicare saves between \$13 and \$14 for each dollar spent on fighting fraud. Funding for this is not capped. It has been flat for several years but increased in the current year. Medicare Integrity funds must be spent on five areas: Medicare secondary payer program, outreach and education, audit (hospital cost reports), benefit integrity (fraud), and Medicare review (review of claims). In recent years, CMS has been working successfully to increase the amount of discretionary funding granted by Congress. These funds support projects such as the "Do Not Forward" program for suppliers, which helps CMS identify closed DME suppliers and target investigations, and expanded contractor task orders related to anomalous billing patterns.

Member Comment – Mr. Roberts asked Ms. Vriezen to describe the prospective review program and whether she felt the adoption of EHRs will facilitate the identification and prevention of fraud.

CMS Response – Ms. Vriezen replied that the contractors are working on intercepting fraudulent claims before they are paid. She anticipated that EHRs should help because they will provide more real-time data. She hoped that the technology will evolve to allow for the interception of fraudulent claims within the mandatory 30-day payment window.

Member Comment – Dr. Jones inquired whether mechanisms exist that allow CMS to determination whether complaints actually represent fraud or are a result of beneficiary displeasure with the ways services were provided.

CMS Response – Ms. Vriezen stated that the Claims Service Representatives now spend more time working with callers to determine the circumstances surrounding the services provided. Conversations focus more proactively on questions instead of simply listening to the complaint.

Member Comment – Dr. Cruz informed Ms. Vriezen that the National Hispanic Council on Aging runs a Medicare fraud program, in partnership with AoA. She offered to share the findings of its needs assessment related to Medicare fraud in the Texas area.

Member Comment – Dr. Yee asked to what extent fraud investigations are linked to limited English proficiency.

CMS Response – Ms. Vriezen noted that CMS is growing concerned about problems that border on public health, especially in South Florida and Texas, related to the conversion of a large number of oral diabetics to injectable diabetics (a home health service). Poverty and low English proficiency are potential factors in this phenomenon. Additionally, she indicated that there might be cultural factors coming into play that relate to a sense of entitlement. CMS is working with the Florida Medical Association to better understand this issue.

Ms. Snead asked panelists to focus their comments on how CMS can better engage beneficiaries.

Member Comment – Dr. Green expressed concerns that CMS' efforts seemed to be targeted at urban areas, where low English proficiency and minority populations are clustered. Medicare fraud happens everywhere, and other types of communities should also be targeted. She asked if CMS could provide examples of how it is targeting fraud in other types of communities.

CMS Response – Ms. Vriezen explained that data drives CMS' allocation of resources. The data indicates that fraud is concentrated in urban areas. Lately, the agency has noticed some potential problems in rural areas related to home health services and the lack of a related physician visit. CMS is trying to determine how best to provide for situations such as a patient moving to a new area but continuing to use a physician in the old area.

Member Comment – Dr. Green did not find Ms. Vriezen's answer satisfactory. She was interested in learning more about the data and its source(s). In particular, she expressed concerns

over unintended consequences related to care provided to dual-eligibles and concerns that some physicians might come under greater scrutiny because of the patient populations they treat.

Member Comment – Ms. Snead restated Dr. Green’s comments by noting that the outreach strategies developed by CMS should cross all segments and that resource allocation must be based on sound principles.

Member Comment – Dr. Frank asked if beneficiaries receive letters confirming their receipt of home health services or DME. He suggested that CMS provide beneficiaries with a self-addressed, stamped envelope that they can use to confirm that they are indeed receiving the equipment or services for which Medicare is being billed.

CMS Response – Ms. Vriezen replied that Medicare does not send out confirmation letters, and indicated that doing so was a good suggestion.

Member Comment – Ms. Bronson observed that publicity concerning Medicare’s fraud activities could be a double-edged sword. Successful efforts could underscore the perception that the government is inept at managing the program and that fraud is rampant. She asked how CMS handles this issue.

CMS Response – Ms. Vriezen replied that CMS prefers to get its fraud messages out to the public, even if it has the potential to reinforce negative perceptions. Medicare does not get much credit for enforcement actions because they are conducted by law enforcement agencies, even though the agency provides the information that makes the actions possible. She anticipated that funding for fraud-related efforts will continue to increase.

Member Comment – Ms. Hughes asked if there are any statistics on the annual proportion of Medicare outlays that result from fraud.

CMS Response – Ms. Vriezen stated that fraud costs are difficult to quantify but are estimated to be between \$60 million and several hundred million annually. CMS has several projects attempting to determine actual costs. CMS can measure improper payments (mistakes on claims) for both Medicare and Medicaid.

Member Comment – Ms. Snead asked about the guidance provided to the contractors and expressed concerns that legitimate errors are lumped in with fraud. She advocated for the standardization of terminology and for incorporating standard terms into education and outreach efforts.

Member Comment – Dr. Jones pointed out the challenge of getting new physicians to accept Medicare patients due to their fears of being charged with fraud, which has the potential to make them unacceptable to civilian plans. CMS needs to use normative data to drive its reviews and inquiries. Additionally, the agency should not segment providers for targeting reviews.

Member Comment – Dr. Yee asked to what extent CMS works with intermediaries or other entities to determine whether a beneficiary receives a benefit, especially in areas where there have been reports of fraud.

CMS Response – Ms. Vriezen indicated that the PSCs, carriers, and intermediaries are more cautious when there have been reports of fraud. The recovery audit contractors look at records after claims are paid. There is a desire within the agency to focus more on pre-pay efforts to identify fraud.

Member Comment – Ms. Markwood observed that fraud received much coverage during the discussions related to health care reform. She cautioned that it not be the focus of public messages about Medicare. Messages need to focus on benefits and promote the idea that CMS is working to improve the program.

Public Comment

Ms. Deborah Schreiber, United Health Group (UHG), works on compliance issues related to CMS regulatory obligations and marketing guidelines for Medicare beneficiary communications. She identified three areas in which UHG is interested in collaborating with CMS, specifically plain language, dual-eligible communications, and alternative media/electronic communications.

UHG is supportive of CMS' efforts to improve the use of plain language in consumer education communications. The organization has developed a guide, *Just Plain Clear*, for internal use. Ms. Schreiber asked Ms. Falconi to share the copy of this guide provided to CMS with panel members and welcomed any feedback they might have.

She reported that her organization has received feedback from its members indicating that the CMS model documents and disclaimers are not easily understood by the dual-eligible population. UHG would like to work with CMS on improving the language in these documents and disclaimers, including developing customized language for the dual-eligible population.

UHG is also interested in partnering with CMS on the further development of guidelines for the use of alternative media for communicating with beneficiaries in a less restrictive way than is currently allowed while still ensuring beneficiary protection.

Meeting Recap, Recommendations, and Next Steps

Rebecca Snead, APME Chair

Sandy Markwood, APME Co-Chair

Panel members shared final thoughts and recommendations related to the day's discussions. Dr. Jones noted that the medical community is considering how to leverage technology to support patient encounters and distance patient management. He expressed hope that CMS would consider these evolving trends in its DME evaluations. Ms. Hunt added that health care reform includes new requirements related to "Welcome to Medicare." She suggested that the APME

take on the Welcome to Medicare message as a topic of discussion. Ms. Snead indicated that the Welcome to Medicare initiative could also serve as a means of amplifying messages related to reform. Mr. Roberts supported further discussion of the inventory of provider burdens and the opportunities the burdens represent with regard to patient relations. Dr. Green added that the panel was very interested in the development of one-page information sheets concerning health care reform topics and in gaining access to Congressional Research Service products related to its work. She also asked CMS to make the data related to targeting fraud investigations available for review.

Ms. Markwood highlighted areas in which CMS asked for guidance and support as well as areas in which panel members felt the APME could play an increased role:

- CMS asked for feedback related to innovative products and programs that will help beneficiaries as well as ways to encourage them to accept new programs and products.
- CMS requested that panel members and their organizations serve as interpreters and partners in disseminating messages concerning health care reform targeted toward consumers.
- CMS asked the panel to suggest ways to motivate physicians to adopt EHRs and to educate consumers about their benefits.
- CMS requested that the panel identify ways to further engage beneficiaries in efforts to identify fraud.
- The panel expressed interest in helping individuals take greater responsibility for their own health.
- The panel also saw an opportunity to craft education and outreach messages within the Welcome to Medicare initiative.

Adjourn

Cindy Falconi, Acting Designated Federal Official, OEA, CMS

Ms. Falconi thanked the panelists and speakers for their participation. She announced that the next APME meeting would take place on June 22 and adjourned the meeting.