

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 425A
Washington, DC 20201
Wednesday, July 22, 2015

Executive Summary

Opening

Abigail Huffman, Designated Federal Official (DFO), Office of Communications (OC), CMS

Ms. Huffman called the meeting to order at 8:31a.m. EDT and welcomed participants. The panel will hear public comments at 3:15 p.m., and anyone interested in making a comment should sign up at the registration desk. Lobbyists should identify themselves as such.

Welcome and Introductions

Miriam Mobley-Smith, Pharm.D., APOE Chair
Susie Butler, Director, Partner Relations Group, OC

Dr. Mobley-Smith welcomed panelists and guests. Panelists introduced themselves. Ms. Butler thanked everyone for coming, noting that this was the last meeting for a number of APOE panelists. She said CMS appreciates the feedback it receives from APOE.

Certificates of Appreciation with Photographer

APOE Members and Ms. Butler

Ms. Butler presented departing panelists with certificates of appreciation. Departing panelists and the entire panel were photographed for APOE archives.

Recap of March 19, 2015 Meeting

CMS Response to APOE Recommendations

Dr. Mobley-Smith
Ms. Butler

The March 19 meeting began with a recap of the December 14, 2014 APOE meeting, including lessons learned from the inaugural launch of the Affordable Care Act (ACA). Four presentations followed the recap.

Marketplace “After Action” Plan: A rich discussion resulted in a large number of recommendations. Recommendations were incorporated into the discussion session. They addressed the need for additional messaging about the importance of obtaining health insurance, engagement of additional partners, improvement of the application and enrollment process, better tools and resources for consumers to find information, improved education about plan structures, a transition roadmap to Medicare, health literacy, consumer focus groups, analysis of

enrollee characteristics, and enhanced training for assisters and call center employees. CMS' goal is to ensure that its ongoing program improvement efforts and strategies will effectively identify and address the most important areas of need.

Communications Strategy for Open Payments Act: The Act is mandated by section 6002 of the ACA and is also known as the Physician Payments Sunshine Act. It provides public information about financial relationships between physicians and teaching hospitals and drug and device makers. CMS aggregates the data and makes it available to the public. The panel made six recommendations; CMS accepted five of the recommendations and partially accepted the sixth.

The first recommendation was to stratify and clarify the data presentations that industry reports to CMS, to improve the ability of providers to make the information more meaningful for consumers and incentivize providers to ensure data accuracy. In accepting the recommendation, Ms. Butler commented that CMS is always looking for new ways to present the data in the clearest and most user-friendly way possible and will continue to refine and clarify Open Payments data.

The second recommendation was to reorient the focus from provider awareness to consumer awareness. CMS accepted the recommendation, noting the importance of including consumer awareness in outreach efforts.

The third recommendation was to clarify the goals and purpose of the Open Payments Act through a variety of materials and outreach efforts. CMS accepted the recommendation and will reiterate program goals in future outreach materials.

The fourth recommendation was to collect, analyze, and validate the reported payment data and assess what people are looking for from this information. CMS accepted the recommendation and will get feedback for the suggestions from focus groups and stakeholder meetings.

The fifth recommendation was to use stories in the media to illustrate how the data can be used. CMS accepted the recommendation. Ms. Butler said CMS will use a social media campaign to solicit and collect stories from providers about their experience with data review.

The sixth recommendation was to place more emphasis on the name "Sunshine Act," because it conveys the purpose of the Act. CMS partially accepted the recommendation and will tailor communications to the targeted audience. The program's branded name is "Open Payments," but some communications will refer to it as "formerly known as the Sunshine Act."

Implementation of Provision 4159: The provision defines the providers who have the authority to write prescriptions for Part D drugs. APOE made nine recommendations, and CMS accepted seven and partially accepted two.

The first recommendation was to stratify and segment unenrolled prescribers to understand the barriers preventing enrollment. CMS accepted the recommendation and is reviewing available data segmenting unenrolled providers by specialty and geography to devise an outreach strategy.

The second recommendation was to create another category for non-Part A/Part B providers, clarify their roles, and communicate the requirements to APOE. CMS accepted this recommendation and posted a new rule, which it will continue to clarify.

The third recommendation was to construct provider communications and messaging to be more corrective through June 1, 2015, and more personalized and urgent after that. CMS accepted this recommendation and has formed a Medicare Part D Provider Enrollment Communications Workgroup to coordinate outreach efforts. Frequent mail updates will be available for providers.

The fourth recommendation was to access the database used by the Council for Affordable Quality Healthcare (CAQH) to obtain more accurate contact information for unenrolled prescribers. CMS accepted this recommendation and is working with CAQH to access the data.

The fifth recommendation was to provide resources such as pre-populated enrollment forms and use of electronic signatures to speed the enrollment process. CMS partially accepted this recommendation. It cannot accommodate use of pre-populated enrollment forms. Electronic signatures are currently allowed, and CMS is promoting online enrollment.

The sixth recommendation was to partner with and leverage Part D plans for enrollment assistance with their respective networks of providers. CMS accepted this recommendation and has been coordinating regular stakeholder meetings with plans to discuss Provision 4159.

The seventh recommendation was to carefully construct messages for Part D enrollees, with advice about changing providers if necessary, without creating undue alarm among consumers. CMS accepted the recommendation and has issued an interim final rule with comment period to allow for provisional filling of a prescription from an unenrolled provider.

The eighth recommendation was to leverage the range of professionals who work with prescribers and be mindful of the potential impact of non-enrollment on medical homes. CMS accepted the recommendation and will work with a broad array of partner organizations to reach unenrolled providers.

The ninth recommendation was to provide continuing medical education on enrollment and consequences of noncompliance. CMS partially accepted the recommendation and will engage professional office staff and reach out to professional associations.

Delivery System Reform: Health Care Payment Learning & Action Network (HCPLAN):

Patients are valuable stakeholders, and CMS seeks their feedback and wants to increase opportunities for patients and caregivers to communicate with the agency. APOE proposed eight recommendations; CMS accepted four, partially accepted one, accepted two with qualification, and found another out of scope.

The first recommendation was to engage consumers and community-based organizations in the HCPLAN. CMS accepted the recommendation and has mounted a broad stakeholder outreach strategy and is building a diverse network.

The second recommendation was to provide more assistance and peer education for providers to partner with non-health care organizations to improve outcomes and cost savings. CMS accepted the recommendation and is working with the MITRE Corporation to find online tools that would facilitate information sharing. CMS also is considering establishment of an Online Payment Learning Resource Center that would facilitate a range of partnerships.

The third recommendation was to emphasize the role and responsibility of providers in care coordination as a pathway to good patient outcomes. While CMS supports the idea, it cannot accept the recommendation because it is beyond the scope of HCPLAN as well as CMS' role.

The fourth recommendation was to conduct focus groups with patients in systems engaged in alternative payment arrangements and share their information. CMS accepted the recommendation with qualification. CMS cannot unilaterally direct the activities of HCPLAN.

The fifth recommendation was to lead reform efforts to reach critical mass participation as the key pathway toward sustainable payment reform. CMS accepted the recommendation with qualification. CMS is an HCPLAN participant, and does not lead or direct the network.

The sixth recommendation was to engage consumers around the issue of value and what they want from their health care encounters. CMS accepted the recommendation and continues to support a range of opportunities to engage consumers.

The seventh recommendation was to provide outreach and education for consumers and providers about payment reform and system transformation. CMS accepted the recommendation, noting that HCPLAN will address these goals.

The eighth recommendation was to provide a roadmap for providers showing the future of payment reform and tools they can use to talk about changes with their patients. CMS partially accepted this recommendation. Again, HCPLAN will address these issues.

How to Simplify Cost Sharing Reductions

Patricia Meisol, Health Insurance Specialist, Division of Policy and Analysis, Payment Policy & Financial Management Group, Center for Consumer Information and Insurance Oversight

Cost-sharing reductions (CSRs) are subsidies that reduce out-of-pocket spending, such as for deductibles and co-pays. They are intended to help low- and moderate-income individuals afford needed health care services. Individuals with household incomes between 100 and 250 percent of the federal poverty level who are enrolled in a silver level qualified health plan through an individual market exchange are eligible for CSRs. The amount of the CSR is related to the plan's actuarial value.

Of the 10.2 million consumers enrolled in qualified health plans as of May 2015, 85 percent qualified for financial assistance. This can be in the form of advanced premium tax credits and/or CSRs. More than half of consumers are eligible for both. With tax credits, 80 percent of consumers can receive coverage for \$100 per month or less.

Issuers, who receive their information from CMS or the state-based exchange, are responsible for assigning enrollees to the correct plan to qualify for CSRs, based on eligibility and income. The process is complex, with multiple choices available, and consumers must choose between a bronze plan with a lower premium and a silver plan with a higher premium and CSR. CMS is working to simplify the process and make it more transparent to make it easier for consumers to obtain CSRs and understand the value of their coverage.

Issuers must design new plans and products to meet ACA standards for CSRs and communicate with multiple constituents (e.g., patients, providers, CMS) to update information that determines CSR amounts advanced to issuers and out-of-pocket amounts paid by consumers. CMS pays insurers in advance to offset the cost of CSRs. Insurers must reconcile advance payments they receive from CMS with actual cost sharing provided to eligible enrollees and make adjustments when necessary. The methodology for determining CSR reconciliation is very complicated.

CMS has learned that issuers need more time to build a system that can re-adjudicate claims twice and decided to delay reconciliation for one year. The agency will reconcile 2014 cost-sharing reductions in April 2016, rather than April 2015, to allow more issuers to use the most accurate reconciliation method.

The next steps are to make it easier for issuers to provide CSRs with further automation of the back-end payments to issuers and improve and enhance infrastructure to make the process easier for issuers. Ms. Meisol welcomed suggestions from APOE about how CMS can make it easier for issuers to provide CSRs and reconcile them against advance payments.

Recommendations for How to Simplify Cost Sharing Reductions

Panelists divided recommendations in two categories: how to improve transparency to help consumers find the best option for their needs and how to make it easier for issuers to provide CSRs and reconcile them against advance payments.

Recommendations in the first category included ensuring that the shopping tool on healthcare.gov informs CSRs, training navigators and assisters about the impact of not selecting a silver plan when eligible for CSRs, and developing an out-of-pocket cost calculator to use when enrolling. Also, information about CSRs should be in appropriate languages, culturally sensitive, and explained simply with realistic scenario-based examples. The website should sort plans and use other tools such as pop-up boxes, messages, and flags to help make silver plans the first and easy choice for consumers who qualify for CSRs. Issuers could be required to specify the amount of savings an enrollee could save by selecting a qualifying silver plan.

In the second category, CMS should clarify definitions for issuers, allow a midterm process for reconciliation, and devise a better mechanism for explanation of benefits so that the true value as well as what is being paid can clearly be communicated to the consumer. A standardized software tool for reporting would be useful.

Health Outreach to Transitioning Veterans

Lynne Johnson, Deputy Director, Partner Relations Group, OC, CMS

Melinda Manyx, Curriculum Specialist for Transitions Development

A new partnership will work to ensure that military members separating from service know that health care benefits are available for them and how to access them. For many, this is their first experience looking for health care. The Department of Defense (DoD) Transition Assistance Program will serve at least 250,000 transitioning veterans in person and 25,000 online this year.

CMS is working with the DoD Transition to Veterans Program Office to produce a video about health insurance enrollment and insert it into its financial planning curriculum. It provides an overview of the Marketplace. The video, which will be available in the classes and online, will address the special circumstances of former military members in transitioning from Tricare, the military health insurance system, which is free to members of the military and their families, to private health insurance. Veterans will be included as a special population on Marketplace.cms.gov.

The video, which will be completed by September 1, 2015, has used a number of partners including the military services, the National Military Family Association, the Veterans Health Administration, and the Center for Minority Veterans. The 3- to 5-minute-long video will use language that is familiar to veterans and will provide suggestions of where to go for more in-depth information such as CMS' Coverage to Care program.

APOE feedback about how to reach transitioning veterans and their families and what to include on factsheets and accompanying materials that target veterans will be helpful in the final steps of preparing the video.

Recommendations for Health Outreach to Transitioning Veterans

Panelists emphasized the need for partnerships to disseminate the video. Possible partners include institutions of higher education, churches, mental health clinics, libraries, free clinics, employers, state veterans commissions, veterans groups, county groups, community-based organizations, and federally qualified health centers. Homeless veterans are an important group to target. Consider barriers. Research and focus groups need to address the wide age and income range of personnel who are separating from the military. Messaging should highlight the risk of not enrolling in a health plan. The video also should include information on the full continuum of coverage options for transitioning military personnel and their families including Medicaid, the Children's Health Insurance Program, and Marketplace coverage. Assistants can develop enrollment events for individuals as they transition out of military service. The panel recommended evaluation of the impact of the video to inform future efforts. Consistency with information from Marketplace.cms.gov is important. Explore navigator cohorts to determine who already has experience working with veterans, particularly homeless veterans. Ensure that video materials are in languages that reach the diverse spread of languages in the veteran population. APOE recommended a 2nd to 3rd grade literacy level for the video. Finally, it might be useful to make the video available for the panel to review for comment.

Overview of Comprehensive Care for Joint Replacement Proposed Rule

Mimi Toomey, Director, Stakeholder Engagement and Policy, Policy and Programs Group, Center for Medicare & Medicaid Innovation, CMS

The model for Comprehensive Care for Joint Replacement (CCJR) was sent to the Federal Register on July 8 and is in the public comment phase of rule-making. The model would test bundled payments for lower extremity joint replacement (LEJR) across a broad cross-section of hospitals and would apply to most Medicare LEJR procedures within select geographic areas. The performance period would begin on January 1, 2016. It is designed to address the many disparities in cost and quality of hip and knee replacements.

The CCJR model is designed to provide better, more coordinated, higher quality, and more economic care for patients during and after a hip or knee replacement surgery. The goal is healthier people and healthier communities. The model coordinates care among hospitals, physicians, and other health care providers. It will include Inpatient Prospective Payment System (IPPS) hospitals in 75 selected metropolitan statistical areas.

An episode is defined as major joint replacement or reattachment of lower extremity with or without major complications or comorbidities and includes hospitalization, 90 days post-discharge care, and all Part A and Part B services related to the episode. All services would be fee-for-service and include physicians' services, inpatient hospitalization and readmission, inpatient psychiatric care, long-term hospital care, inpatient rehabilitation facilities, skilled nursing facilities, home health agencies, hospital outpatient services, independent outpatient therapy, clinical laboratory, durable medical equipment, Part B drugs, and hospice.

The risk structure is a retrospective, two-sided risk model with hospitals bearing financial responsibility. Providers and suppliers would continue to be paid via Medicare fee-for-service. After a performance year, actual episode spending would be compared to the episode target prices and reconciled if necessary. Hospitals must meet a minimum threshold on three quality metrics to be eligible for reconciliation payments. Thresholds for performance would increase over the lifetime of the model to incentivize continuous improvement.

Some overlap is possible with CMS' Bundled Payments for Care Improvement initiative and affordable care organization models. Hospitals are permitted to have financial arrangements with collaborators to improve quality and reduce costs, and waivers of federal fraud and abuse laws will be considered when appropriate. Beneficiaries' access to other care would not be impacted by the CCJR model. Beneficiaries will be notified of payment implications of CCJR. CMS will closely monitor for potential risks of financial arrangements or compromised quality and take necessary actions to address lack of compliance with CCJR model requirements.

The model will be evaluated for payment and utilization impact, outcomes and quality, referral patterns and market impact, unintended consequences, and potential for extrapolation of results.

Comments can be submitted electronically at <http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html?redirect=/eRulemaking> or on paper

by following the instructions included in the proposed rule by September 8, 2015. Questions can be sent to ccjr@cms.hhs.gov.

Ms. Toomey said she hoped APOE recommendations would increase understanding of the rule and help with outreach. Hospitals bear ultimate responsibility for coordinating care.

Recommendations for CCJR Proposed Rule

Panelists expressed doubts about the proposed rule and recommended consideration of the risk and benefit to the patient, the effect outside the hospital, and the effects of bundling if all providers are receiving fee for service. A fact sheet is needed to clarify the roles of all collaborators including care coordinators, providers, and Medicare administrator contractors. More information is needed from leading hospital systems (particularly those that have achieved successful care coordination of joint replacements), integrated systems, primary care associations, nursing home associations, and the Program of All-inclusive Care for the Elderly. The patient also needs to be part of the model. The model needs alignment among the patient, the payer (CMS), and providers.

Public Comment

Jim Tozzi, Ph.D., Center for Regulatory Effectiveness

Dr. Tozzi's organization serves as a regulatory watchdog. He emphasized the importance of the quality of care that beneficiaries receive from CMS programs.

Recap of Meeting and Final Comments

Marjorie Cadogan, APOE Co-Chair

Ms. Cadogan said the panel had thoughtful suggestions about CSRs, including the need to bring in collaborators such as the navigator community so that they can understand the impact of cost sharing, and how to make CSRs easier for insurers and beneficiaries. There were also recommendations for additional partners to be part of outreach to help transitioning military personnel understand health care enrollment. The panel had a thought-provoking discussion about the CCJR proposed rule, the need to consider all stakeholders, and the importance of quality as well as financing. The comment from Dr. Tozzi also urged a close examination of quality issues. Ms. Cadogan thanked everyone for their participation, noting that many will soon be leaving the panel.

Adjournment

Ms. Huffman, DFO, CMS

Phillip Bergquist, APOE panelist, said he would like to see a discussion of dual eligibility at the next APOE meeting. Ms. Huffman agreed. Ms. Huffman adjourned the meeting at 3:27 p.m. EDT.