

**Meeting of the Advisory Panel on Medicare Education (APME)
Centers for Medicare & Medicaid Services (CMS)
July 8, 2009
Hilton Washington Hotel Embassy Row
Washington, DC 20036**

Location:

The meeting was held at the Hilton Washington Hotel Embassy Row, 215 Massachusetts Avenue, NW, Washington, DC 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

Cathy C. Graeff, R.Ph., M.B.A., Senior Vice President, Communications and Industry Relations, National Council for Prescription Drug Programs

Carmen R. Green, M.D., Associate Professor, Department of Anesthesiology, and Director, Health Disparities Research Program, University of Michigan Health System

Jessie C. Gruman, Ph.D., President and Executive Director, Center for the Advancement of Health

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

Kathy Hughes, Vice Chairwoman, Oneida Nation

Frank B. McArdle, Ph.D., Manager, Hewitt Research Office, Hewitt Associates

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

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

Panel Members Absent:

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

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

Andrew Kramer, M.D., Professor, Medicine and Director, Center for Health Services Research, University of Colorado, Denver

Robert L. Mollica, Ph.D., Senior Program Director (retired), National Academy for State Health Policy

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

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

Open Meeting

Lynne G. Johnson, Designated Federal Official, Office of External Affairs (OEA), CMS

Lynne Johnson called the meeting to order.

Welcome and Introductions and Review of Previous Meeting and Subgroup Activities

Rebecca Snead, APME Chair

Mary Worstell, Director, Partner Relations Group, OEA, CMS

Ms. Rebecca Snead welcomed the panelists and briefly reviewed several housekeeping items before asking the panelists to introduce themselves. She reviewed new materials for the members' binders and summarized the proceedings of the April 22, 2009, APME meeting. During the April meeting, panelists approved a document developed to guide future activities of the panel; engaged in discussions of the *Medicare & You* handbook, the Centers for Medicare & Medicaid Services' (CMS) research agenda, and the role of the State Health Insurance Assistance Programs (SHIPs); participated in a listening session with CMS leadership; and heard public comment on the Medicare Rights Center's Web site.

Ms. Mary Worstell explained the process used to develop the agenda for each APME meeting. Three considerations drive the agenda: the panel's suggestions, the information that CMS needs to share, and the need to provide the panel with information on CMS activities early on to maximize the panel's input into the development of products and processes. The areas of greatest interest to panelists seem to be beneficiary self-engagement, new ways of communicating with beneficiaries, the Medicare Web site and how consumers use Web-based tools, and the engagement of local, nontraditional partners to help disseminate messages. She asked the panel members to hold CMS accountable for the items it promises to follow up on and to be candid in their comments.

There were no registered lobbyists in attendance.

Listening Session with CMS Leadership

Charlene Frizzera, Acting Administrator, CMS

Ms. Charlene Frizzera told panelists that she planned to address the suggestions included in the letter that they sent following the April meeting. She recognized Dr. Frank McArdle for his work as part of the panel and presented a plaque in recognition of his contributions.

Ms. Frizzera highlighted some of the changes at the Department of Health and Human Services (DHHS) and CMS since the last meeting. CMS is working now to lay the groundwork to implement anticipated health care reforms. Although there are many proposals being considered, CMS is looking at what is similar in all of the proposals, with an emphasis on the House bill, to help it start planning for the next few years. In general, CMS sees eight areas of action. The first three areas relate to program reforms for the Medicare, Medicaid, and Children's Health Insurance Program programs. The five other areas that CMS expects to be affected by reform are coverage gateways (health insurance exchanges, health care administration, and the public plan); quality; long-term care; fraud, waste and abuse; and workforce issues.

Ms. Frizzera interwove her responses to the panel's letter throughout the listening session, with the impending health care reform as an overarching theme.

With regard to the *Medicare & You* handbook, Ms. Frizzera noted that CMS is limited by its congressional mandate. However, CMS is currently talking to Congress about the handbook, specifically about what form it should take and what it should include. CMS plans to continue with the current form of the handbook but is trying to figure out what the handbook might look like in the future and how to transition between forms. One suggestion being considered is a DVD guide to the handbook that explains how to use the handbook and helps users figure out what information they need and what does not apply to their situation. Ms. Frizzera expects that CMS would test the guide before sending it to the full Medicare population and asked that panelists share their thoughts on how best to test/pilot the DVD and whether it should target any special populations. She also asked them to provide her with their ideas on what should be included in any new legislation relating to the handbook.

Member Comment—Dr. Jessie Gruman asked CMS to provide panelists with copies of the current legislation.

CMS Response—Ms. Frizzera replied affirmatively. She stated that the legislation requires CMS to send copies to every beneficiary, which CMS interpreted as mailing to every beneficiary. Subsequent requirements for distributing additional information eventually rolled into the handbook because it was an annual mailing. She promised the panelists a chronology of the evolution of the handbook.

Member Comment—Ms. Kathy Hughes suggested that CMS use the Aging and Disability Resource Centers, which are becoming an increasingly important resource for seniors, as a means of distributing the DVDs.

Member Comment—Ms. Gwendolyn Bronson asked Ms. Frizzera to confirm that the legislation only includes current beneficiaries, not those getting ready to enter the program.

CMS Response—Ms. Frizzera replied that she believed that was the case, although CMS did send materials to those nearing Medicare eligibility. Ms. Susie Butler, Director, Division of Provider Affairs, OEA, CMS, confirmed that a handbook is included in the enrollment package.

Member Comment—Dr. McArdle suggested that new handbook legislation require CMS to make the handbook available to all beneficiaries in an accessible and understandable format.

Member Comment—Ms. Sandy Markwood asked how CMS could incorporate the handbook into intergenerational learning and communication to help educate people about Medicare before they are eligible for it.

CMS Response—Ms. Frizzera replied that CMS has been doing a lot of work on baby boomers. They have been surprised to find that many boomers are well educated about Medicare because of their roles as caregivers and because of the increasing level of discussion surrounding reform. CMS's particular challenge is to figure out how to get to those approaching eligibility without overloading them with information. Baby boomers do not seem to be following similar patterns as the generations that came before. Experts expect more boomers to age in place, which has important implications for health care infrastructure and workforce needs.

Member Comment—Dr. Carmen Green pointed out the problems of getting mailings to the homeless. She saw this as an opportunity to engage social workers and hospitals in this effort. She also suggested CMS use the handbook to calm seniors' fears about Medicare going bankrupt and to help educate them about making health care decisions based on value and quality, not just cost. Dr. Green also suggested that CMS could get feedback on the handbook from seniors through the resource centers in minority aging research.

CMS Response—Ms. Frizzera told beneficiaries that CMS is very concerned about how it should communicate with beneficiaries about reform. Beneficiaries have heard many different things about reform and the status of the Medicare trust fund, and they fear that they will lose their health care. CMS has designed a script about reform for use by the call center customer service representatives (CSRs), but needs to develop a long-term approach/campaign to inform beneficiaries about reform as it develops and what it means for them without increasing their fears. She asked panelists for their suggestions.

Member Comment—Dr. Green suggested that CMS could educate elders without going into too much detail. She thought that CMS should focus on explaining concepts such as quality.

CMS Response—Ms. Frizzera replied that she thought that messaging needed to focus on first reassuring beneficiaries that Medicare will be there for them, and then later focus on more specific concepts within reform. People need to get used to the idea that things will change. CMS is working on gathering feedback both from its internal sources (such as the hotline) and from its partners.

Member Comment—Dr. McArdle suggested that CMS focus on short-term messaging and let beneficiaries know that the details are still up in the air but that CMS expects to have more information in a few months. Messages should also give beneficiaries a sense of the timeline for implementation of the changes and explain what the reforms will mean for beneficiaries (not the general public).

CMS Response—Ms. Frizzera responded that CMS wants to communicate proactively, but that the agency is still trying to figure out what people are asking. CMS would like to know what other groups are hearing from beneficiaries. CMS has been active in its communications as well as addressing the questions received by the agency.

Member Comment—Mr. Stephen Fera expressed concerns that health care reform legislation could pass in October, further complicating the open enrollment season. He anticipates that there will be lots of confusion from October 2009 through March 2010, especially for those with Medicare Advantage plans, even if reform does not pass. Member Comment—Dr. Yanira Cruz suggested that CMS consider hosting community forums as a way to hear from older adults, especially for certain population groups or audiences.

CMS Response—Ms. Frizzera asked Dr. Cruz to provide CMS with summaries of the findings of each of the forums and asked all of the panelists to send any information they had on beneficiary concerns to Ms. Worstell.

CMS Response—Ms. Frizzera explained that CMS and the Social Security Administration (SSA) work together to provide beneficiaries with information. SSA includes CMS information in its packets.

Member Comment—Dr. Green indicated that Medicare and SSA mailings offer opportunities for increasing efficiency, eliminating overlaps, and determining if everything that is being sent out really needs to go out. She suggested that CMS needs to thoughtfully consider its dissemination plan and base it on feedback from elders. She also suggested that CMS target the daughters (or other caregivers) of beneficiaries.

CMS Response—Ms. Frizzera indicated that CMS is working closely with SSA and that CMS is actively reaching out to caregivers. She asked panelists to suggest ideas they would like to see in messages for both caregivers and beneficiaries.

Member Comment—Ms. Snead stated that CMS needs to engage providers to reinforce positive messaging. She suggested that CMS consider taking an approach similar to that taken by the public health agencies with regard to the recent concerns over the use of acetaminophen. This messaging should emphasize the role of CMS as a partner in beneficiaries' health.

CMS Response—Ms. Frizzera replied that CMS is working with its sister agencies within DHHS to share and reinforce messages. The Medicare Web site includes links to the other DHHS agencies' pages. There is a constant struggle between sharing messages while retaining a distinct identity. Messages need to be targeted to the right people at the right time.

Member Comment—Dr. Green cautioned CMS not to be too reliant on its Web site.

Ms. Frizzera next addressed the panel's comments on CMS' research agenda. She indicated that it would be helpful if the panel could provide specific examples to illustrate its points. For instance, Ms. Frizzera indicated that CMS does coordinate research across the agency to find efficiencies and does publish its research on its Website.

With regard to the decision-support tools and the use of rating stars, Ms. Frizzera indicated that CMS gave considerable thought to their use. There is an ongoing struggle to provide good tools but not to wait too long while the agency develops the "perfect" measure and the "perfect" data. Ms. Frizzera told panelists that CMS conducts lots of follow up to see why beneficiaries are using the tools. CMS found that the tools are not the only resource beneficiaries use to make their decisions and that many users would like the tools to address a wider range of issues. She asked panelists to identify alternate measures and ways to educate beneficiaries about what is and is not included in the various tools, especially with regard to quality.

Ms. Frizzera indicated that CMS agrees completely with the panel's recommendation with regard to the SHIPs. Because of the complexity of the information, it is a struggle to make it simple for volunteers. She also told panelists that CMS works closely with the SHIPs to incorporate their recommendations and cited the example of how CMS adopted all of the recommendations generated at a recent SHIP conference. Ms. Frizzera indicated that CMS will

talk to the SHIPs about incorporating the panel's suggestions concerning exit interviews and volunteer recruitment.

Ms. Frizzera told panel members that CMS will start making payments to physicians who adopt electronic health records (EHRs) in 2011. Currently, CMS is working to define meaningful use. A draft document regarding this will be available in mid-July. She encouraged panelists to review the document and provide suggestions on what CMS should be telling beneficiaries about EHRs, especially with regard to privacy and security of their information. Medicare offers physicians incentives for adopting; Medicaid imposes disincentives. States are taking the lead in promoting adoption of EHRs. The chronic-care community seems to see a need for EHRs at a higher rate than their peers who serve healthier patients. Anecdotal evidence indicates that beneficiaries are asking their providers about EHRs. Providers are looking for help with regard to communicating with their patients about the benefits of EHRs.

Member Comment—Dr. Gruman noted that this is the first meeting conducted under the new working process. The panel should take the time to review the process. Dr. Gruman suggested that the panelists did not express their concerns with sufficient detail, as Ms. Frizzera's responses indicated that she did not fully understand their recommendations, especially with regard to the research agenda. In the future, the panel should not sacrifice detail in the pursuit of brevity.

CMS Response—Ms. Frizzera asked the panel to tell CMS exactly what it wants from the agency. She stressed the agency's commitment to responding to all of the panel's ideas and recommendations. The more detail and specifics that the panel provides, the easier it will be for CMS to respond.

Member Comment—Ms. Snead agreed with Dr. Gruman's comments on future panel communications with CMS.

Demonstration: Web Slide Shows
Stephen Fera, APME Panelist

Ms. Snead informed the panel that the WebMD representative scheduled to present could not attend. She then introduced Mr. Fera, who discussed Independence Blue Cross's (IBC's) Web slide shows about Medicare on its Site 65 Web page. This presentation was a response to the discussion during the April meeting on Web slide shows as a possible means of explaining the *Medicare & You* handbook.

Mr. Fera said that the Site 65 site was a result of IBC's efforts to ensure that its Medicare Advantage (MA) activities were in sync with IBC's overall corporate activities and to sow seeds for future business. IBC has 220,000 Medicare enrollees, with 141,000 of those in MA plans. IBC serves Philadelphia and four surrounding counties, which include rural populations as well as the predominantly urban populations.

Personally, Mr. Fera has learned more about Medicare and the Web from his parents and their friends. He cited statistics showing that the over-55 segment of the population uses the Internet in the same proportion as those 18-34 years old. The most rapidly growing segment of Web

users is those over age 75. This indicates that the Web is a place for everybody and that CMS should not rely on preconceived notions about Web users. While the Web is not yet as relied upon as a source of information as traditional sources, the more good content is placed on the Web and the more efforts to cross-pollinate traditional means of communications, the more seeds are planted for future users.

Site 65 is the domain name for IBC's plan. The spokeswoman was chosen to bring a softer voice to the plan's aging campaign. The site explains the various parts of Medicare, IBC's role, and how to enroll in an IBC plan. The show starts with a summary and an explanation of the navigation tools. Then users can watch videos on each part of Medicare. Mr. Fera pointed out that the show is very simple and the scripts are based on CMS model language. Focus group testing showed that seniors liked the site. IBC has seen more traffic to the site over time and has begun linking it to its general advertising campaigns, not just its aging campaign. Lessons learned relate to how IBC has links set up and the way the slide shows are segmented. Site 65 allows IBC to explain MA plans and contrast them to original Medicare.

IBC is now putting information from its member meetings, which address annual changes to plans, online to serve those who cannot attend the meetings. Currently, IBC posts the member meeting presentations online with information on where to go for answers to questions they may have. In the coming year, IBC is looking at using a spokesperson on the Web site and adding a direct chat line. The plan wants members to understand that this information is available online on a constant basis. IBC is also considering putting sales presentations online to allow individuals to self-direct to the products that they want.

Mr. Fera said that in the course of talking to beneficiaries about the *Medicare & You* handbook, IBC has referred people to its Web site. The site scored well in comparison to the handbook.

Member Comment—Dr. McArdle asked Mr. Fera to compare the number of people using the Web site to IBC's entire enrollment.

Presenter Response—Mr. Fera replied that the population was small but growing. In an effort to drive traffic to the Web site, IBC is not putting phone numbers on some of its advertising. IBC has seen incremental growth year to year with greater increases in the past year. The plan was to continue to invest heavily in the Web because of its perceived capabilities in order to complement IBC's other activities. An important factor in IBC's plan is the changing demographics of seniors it serves.

Integrating Medicare Tools

Anita Panicker, Deputy Director, Website Project Management Group, Office of Beneficiary Information Services, CMS

Ms. Anita Panicker introduced Mr. Melvin Sanders and Ms. Danielle Harris, who support the development of the Medicare Options Compare (MOC) tool and who were available to help answer questions from the panel. CMS is constantly looking for the panel's feedback on its compare sites, with the MOC being the current focus.

The MOC tool includes an option that allows beneficiaries to enter their drug information to receive more accurate out-of-pocket cost estimates when comparing plans and Part D options. CMS anticipates enhancing this feature to allow beneficiaries to enter their current plan information to further improve the accuracy of the out-of-pocket cost comparisons. The challenge for the umbrella tool is how to provide the information users need without overwhelming them with too much information. Ms. Panicker asked the panelists if they had found any elements of the tool that were not needed and what features (drill downs) could be included but not shown unless specifically called up.

Ultimately, CMS wants to create an umbrella tool for health plans and Part D. CMS is looking for information on how to create this tool and the search options it should include.

Member Comment—Ms. Snead commented that she assumed that many users were not beneficiaries but those who help them (caregivers and family members). These users probably want lots of detail and need to be able to access this information. Ms. Snead indicated that she appreciated being able to save the drug list and suggested that CMS add a feature that reminds users to update their drug lists each time they visit. She also recommended that CMS include some type of caveat to its sort options indicating that users should consider all plans, not just limit their considerations to those with specific characteristics such as dental or vision coverage.

Member Comment—Dr. Green comment that with most beneficiaries taking eight or nine medications, CMS could use the drug list function to identify potential drug interaction and cost savings.

CMS Response—Ms. Panicker replied that CMS is considering adding a drug interaction warning to the Part D tool.

Member Comment—Ms. Snead asked whether the current tool allows users to print out their drug lists so that they can take them to their providers for review.

CMS Response—Ms. Panicker replied that they can.

Member Comment—Dr. Green suggested that drug interaction notices or suggestions for alternative drugs offer CMS an opportunity to do good for patients. As patients age and have more doctors, their doctors may not know what the other doctors are prescribing. Any drug interaction warnings need to have qualifiers that direct users to consult their physicians.

Member Comment—Ms. Bronson agreed that a drug interaction alert would be beneficial and suggested that the tool also remind beneficiaries to review their drug list with their doctors on an annual basis. She expressed concerns over not being able to go back to the screen that shows all the available plans on one page (instead of the screen with only five). Finally, she asked whether the tool indicates that the out-of-pocket costs are only estimates, not exact quotations.

CMS Response—Ms. Panicker replied that costs are identified as estimates. Also, users can now enter their Medigap plan information to get even more accurate cost estimates. Ms. Panicker

also asked panelists to share any questions that they hear on a regular basis from beneficiaries so that CMS could add the appropriate answers to a “Learn More” section.

Member Comment—Mr. Fera noted that increasingly the MA and Medigap plans are coming together and asked if CMS has considered allowing users to compare these using the same tool.

CMS Response—Ms. Panicker indicated that CMS was looking to move toward a blended tool. She expressed hopes that the panel would provide suggestions about this.

Member Comment—Ms. Snead asked if there are any critical components that would prevent the development of a tool that allows users to do this type of comparison.

Member Comment—Mr. Fera replied that major barrier is that Medigap has about 12–14 types of plans. It is like comparing apples to oranges. Perhaps the tool could ask questions on beneficiaries’ preferences (cost sharing levels) within Medicagap policies and then compare cost with those estimated under the various plans.

CMS Response—Mr. Sanders replied that CMS is working on a solution to this challenge. CMS is looking at a cafeteria-style approach that would allow users to input their current coverage and ZIP code to compare their current out-of-pocket cost situation with other options.

Member Comment—Dr. Cruz inquired how CMS is marketing the MOC tool, whether the tool provides a mechanism for providing feedback, and how people without Internet access or computer knowledge can get this information.

CMS Response—Ms. Panicker replied that CMS is marketing the tool through various channels such as other Web sites and links, but that it is not specifically promoting the site. She indicated that the site does include a link where users can go to provide feedback. Ms. Angela James, OEA, CMS, stated that CMS promotes the tools through its various campaigns as appropriate. URLs are usually the first point of reference provided on CMS publications. Most materials include a statement that those without access can go to a library or senior center for help in accessing the Web site. Additionally, hotline callers can get this information via CMS’ print-on-demand service.

Member Comment—Dr. Green stressed the importance of developing dissemination plans as the tools are being created. These plans need to include homeless populations and beneficiaries who do not use the Internet.

Member Comment—Ms. Markwood asked if it is possible for users to save their search results to a folder, like those on social networking sites, that can be shared with family members, caregivers, and providers in order to help them make decisions about their coverage options and disseminate important information. Ms. Markwood acknowledged that there might be security and privacy concerns related to folders.

CMS Response—Ms. Panicker indicated that if children had their parents' identification and access information—and permission—they could log on simultaneously with their parents and view the searches.

Member Comment—Ms. Markwood asked if information could be added to and shared using an identifier and if this information could be disseminated to those interested in the beneficiary's care (e.g., providers).

CMS Response—Ms. Panicker indicated that there are privacy issues that must be taken into consideration. Currently, family members can access individual beneficiaries' information on MyMedicare with beneficiary permission.

Member Comment—Ms. Snead asked if Ms. Panicker was referring to the MyMedicare.gov site and if Ms. Markwood was referring to saving the plan search results and potential choices in the folders.

CMS Response—Ms. Panicker indicated that the plan search results cannot be saved. Users would have to recreate the search each time they visit.

Member Comment—Ms. Snead asked panelists if there were any objections to having an integrated tool that includes MA and Medigap plans instead of the current tools that offer two separate pathways. None were offered.

CMS Response—Mr. Sanders asked panelists to share their ideas on how CMS can best present the information that would result from an integrated tool in a way that would be easily digestible by users.

Member Comment—Dr. Green recommended that CMS include more visual elements, especially people. She suggested that CMS allow users to build characters (avatars) that are visually appealing to users and will guide them through the site much like those used on the Wii game system.

CMS Response—Ms. Panicker replied that CMS already has a glossary on the tool that can be expanded. She expressed concerns about using visuals due to 508 compliance issues, but stated that CMS would look into what can be done.

CMS Response—Ms. Worstell noted that she had noticed seniors watching cartoons in common rooms while she looked for a retirement home for her mother. Cartoons are popular because they are loud, easy to hear, and a simple pleasure. CMS needs to be more observant about what works for seniors. She asked panelists to provide some feedback on how well CMS is marketing the tool and whether there is a natural connection to using the tool among beneficiaries. Ms. Worstell expressed her desire to move away from the idea of adding "just one more thing" to mailings and to avoid the same tendency with the tools while still ensuring that they are as useful as possible. Additionally, she asked whether it is better to train beneficiaries to use the tool themselves or have them come to a center where experienced users can help them and what

implications this might have for self-engagement. Finally, she asked for feedback on how to make the information contained in the tools accessible to those who do not use the Internet.

Member Comment—Dr. Gruman asked if CMS has an option that allows beneficiaries to request that they receive all communications from CMS electronically.

CMS Response—Ms. Worstell replied that beneficiaries can elect to receive the handbook electronically.

Member Comment—Dr. Gruman suggested that CMS could save money by offering this option as well as use the information gathered as part of these requests to support its market segmentation efforts.

CMS Response—Ms. Worstell indicated that this and similar ideas have been discussed, especially with regard to the handbook. Currently, CMS does not have a list of email addresses of beneficiaries interested in receiving information electronically.

Member Comment—Dr. Gruman replied that CMS could use this particular audience to learn more about how to engage people. The bigger idea is not the collection of email addresses; it is the idea of getting people to connect to CMS to start an ongoing dialogue.

Member Comment—Ms. Hughes responded to Ms. Worstell's question about whether CMS' marketing is reaching beneficiaries. She indicated that it is not reaching Native American audiences. Native Americans often lack computer access. This population relies on caregivers and providers who are getting the messages.

Member Comment—Dr. McArdle suggested that CMS consider what it can do with the current tools to leverage and maximize their value without making more additions. He agreed with Dr. Gruman's suggestion about using the tools to better understand its audiences. He also suggested Web sites for financial institutions as a example of communicating complex things to people who usually do not have high subject literacy. Dr. McArdle recommended that the tools ask questions to direct users down the appropriate path and help them understand Medicare better.

Member Comment—Dr. Green suggested making the most of the information provided by Internet savvy beneficiaries by using it to send out culturally sensitive communications and reminders.

Member Comment—Ms. Hughes asked whether CMS could use demographic data from the census to better target age brackets within specific geographic settings for various types of communications.

Member Comment—Ms. Graeff asked whether CMS could use the information provided by beneficiaries on MyMedicare.gov to generate reminders about screenings and other communications.

Member Comment—Dr. Gruman noted that CMS needs to remember that it is a health care financing agency, not a health care agency. Its role as a trusted source that helps people pay for their health is very different from that of a physician who has access to very personal information about patients. CMS needs to focus on its mission.

Member Comment —Dr. Green disagreed with Dr. Gruman and pointed out that more and more insurance companies are sending out targeted information.

Member Comment—Dr. Gruman said that people hate the targeted information and distrust the insurance companies.

Member Comment—Mr. Fera expressed his opinion that the tool is a good tool and helps people understand their options each year. He suggested that tools that focus on wellness might be very different from the MOC tool and what it can do.

Member Comment—Ms. Snead summarized the conversation as an agreement that the tool is excellent, that it is being used primarily by those helping beneficiaries make choices, and that the panel has no objection to combining the compare tools into an umbrella tool as long as CMS proceeds cautiously to address the coming reforms. An important recommendation was for CMS to use its current pool of Web-savvy beneficiaries to learn more about improving Web outreach efforts while still acknowledging the needs of those who are not online.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

Laurence Wilson, Director, Chronic Care Policy Group, Centers for Medicare Management, CMS

Walter Gutowski, Communications Specialist, OEA, CMS

Mr. Laurence Wilson provided a brief summary of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) program, which is rooted in the Medicare Modernization Act. Durable medical equipment (DME) expenditures total approximately \$11 to \$12 billion annually. The goals of the program are to reduce costs to both beneficiaries and CMS, ensure that beneficiaries have access to high quality equipment and services, and ensure that contract suppliers meet financial standards designed to prevent fraud, waste, and abuse and ensure long-term access to supplies. Under DMEPOS, CMS only works with suppliers providing high-quality, competitively priced goods and services. One fourth of Medicare beneficiaries living at home require DME. Because people are in their homes (instead of an institutional setting), it is important to educate them about accessing DMEPOS benefits.

Mr. Walter Gutowski described the original rollout and cancellation (after only two weeks of implementation) of the DMEPOS program in 2008. The 2008 communications program was multipronged. CMS worked with its partners and the SHIPs, in a similar fashion to the Part D rollout, to educate beneficiaries about the program and what they needed to do to ensure uninterrupted access to supplies.

The questions provided to panelists by CMS were meant to stimulate comments from both a professional and caregiver (personal) standpoint. CMS is working hard to get the DMEPOS message out, but needs panelists' input to improve its outreach efforts.

Member Comment—Ms. Snead shared her opinion that the DMEPOS messages were very clear. She indicated that the beneficiary fact sheet, which included a chart on the requirements for residents and visitors to DMEPOS areas, was very informative. She asked if walkers are the only piece of DME that doctors can provide or they are just an example of items that physicians can provide.

CMS Response —Mr. Gutowski replied that a walker is only one of the approximately 10 items that doctors can provide without being a contract supplier.

Member Comment—Ms. Snead suggested that CMS clarify this point in its messages.

Member Comment—Ms. Hughes inquired about the schedule for the DMEPOS program rollout, especially for the national rollout.

CMS Response—Mr. Gutowski replied that the rollout is underway and that the first nine markets start bidding for contracts this year. The second round of 70 areas begins bidding in 2011, and the rest of the country will follow at an unspecified date. The bidding progress must be complete before the program can be implemented for use by beneficiaries. The legislation does not give a specific implementation date for beneficiaries; just start dates for the bidding process.

CMS Response—Mr. Wilson added that the national rollout will occur only in large metropolitan areas. DMEPOS legislation excludes rural areas and smaller metropolitan areas with populations below 250,000.

Member Comment—Dr. Green asked why rural areas and smaller cities are excluded from the program.

CMS Response—Mr. Wilson replied that the decision was principally a congressional one. Legislators were concerned that there might not be enough qualified suppliers in these areas to support the needs of the local population and that the savings to Medicare would not be so great in areas with fewer beneficiaries. However, suppliers in these areas must meet the accreditation requirements and financial standards required under DMEPOS.

Member Comment—Dr. Green expressed her concern that this will disproportionately leave out certain populations, such as those on reservations. She also expressed skepticism that CMS has adequately addressed the quality standards in materials aimed at these populations

CMS Response—Mr. Wilson replied that the Medicare benefit will continue to be available in these areas, but because the competitive bidding process will not take place; beneficiaries may not see the savings in their cost sharing that those in competitive bidding areas might realize.

Member Comment—Dr. Green pointed out that this policy hurts those who most need the savings. Many people in these areas have decreased resources, may not qualify for the low-income subsidy, and may live in resource-poor areas. CMS needs a plan to address the needs of these individuals.

Member Comment—Ms Snead asked if CMS' messaging to beneficiaries in these areas explains why the DMEPOS program is not available to them and why or why not this is so.

Member Comment—Mr. Gutowski replied that CMS would keep this in mind as it develops its materials and provides samples of DMEPOS messages to panelists.

Member Comment—Ms. Graeff asked if CMS has materials for first-time users that explain the DMEPOS program and the importance of using accredited suppliers.

CMS Response—Mr. Gutowski provided an example from the 2008 rollout. At that time, CMS expanded the mailing beyond the initial 10 cities to include all beneficiaries in the respective states. The reasoning was that these people might need DME in the future. This was also a way to educate people in the surrounding areas about the need to use contract suppliers when they travel to the affected cities. CMS feels that it is important to inform a larger audience about DMEPOS as people in unaffected areas will talk to their friends and families in affected areas.

Member Comment—Ms. Bronson asked if the initial nine areas are currently operating under the DMEPOS rules and if contract suppliers are akin to doctors who accept Medicare assignment.

CMS Response—Mr. Wilson replied that CMS is currently collecting bids from suppliers and determining which suppliers will receive contracts. Contracts will not go into effect until January 1, 2011. After that date, only approved suppliers will be able to provide supplies and bill Medicare.

CMS Response—Mr. Gutowski indicated that CMS was cognizant of the importance of this during the first rollout. In 2008, CMS held more than 500 community events supporting DMEPOS education. CMS plans to continue in this vein and expand on the number of community events.

Member Comment—Ms. Snead commented that beneficiaries often learn of their need for DME as part of the hospital discharge process. Hospital discharge planners are a critical component of the education process. Pharmacies, especially in rural areas, are often the first place people go for information on acquiring supplies.

Member Comment—Ms. Hughes pointed out that all Native Americans get their medical care and DME from the Indian Health Service (IHS).

Member Comment—Dr. Gruman asked whether suppliers that did not receive contracts will be expected to refer clients to suppliers that did, whether CMS conducted any evaluation of the original two-week implementation period, and what CMS plans to do with regard to evaluation in the current program.

CMS Response—Mr. Wilson indicated that non-contract suppliers of items such as oxygen, which must be supplied on a recurring basis, are required to notify their clients that they are not a contract supplier. A recently published proposed rule prohibits non-contract suppliers from picking up equipment unless arrangements are already in place with a contract supplier.

CMS Response—Mr. Gutowski stated that during the original implementation, most problems and complaints related to grandfathering issues (rented items only). There were very few problems or emergency situations. CMS did have metrics in place to measure delays in access, disruptions in service, and the speed of processing claims and resolving problems.

CMS Response—Mr. Wilson stated that the current law requires monitoring. CMS has a contract in place to meet this requirement. In 2008, CMS also conducted onsite visits during the initial implementation period and was able to confirm that discharge planners did have the lists of contract suppliers and understood the requirements of using them as DME suppliers.

CMS Response—Mr. Gutowski told panelists that in 2008 CMS had done some pre-implementation research into beneficiary satisfaction with their DME suppliers and supplies/services and planned to do complementary research after reimplementation.

Member Comment—Dr. Gruman asked how CMS stopped the original DMEPOS program after two weeks of implementation.

CMS Response—Mr. Wilson replied that CMS moved quickly to cancel contracts and notify all suppliers, including those that had not won contracts. Suppliers were aware of the possibility that Congress would cancel the program. Some non-contract suppliers kept providing supplies through the implementation period in hopes that Congress would cancel the program. After the cancellation, CMS sent out letters explaining the cancellation to all beneficiaries, discharge planners, providers, partners, and community organizations—essentially every person or group contacted as part of the initial education process.

Member Comment—Ms. Graeff asked if CMS could implement CSR callbacks for people who try to call the hotline about DMEPOS implementation and face long hold times. CSRs could help identify suppliers in callers' areas.

CMS Response—Mr. Gutowski indicated that CMS would consider this. In the first rollout, CMS trained some of its CSRs to use the supplier locator tool. Callers who mentioned competitive bidding were routed to these specially trained CSRs for assistance. CMS plans to do this again.

Member Comment—Dr. Green asked how CMS plans to continuously monitor quality and how CMS plans to reduce waste, fraud, and abuse under the DMEPOS program.

CMS Response—Mr. Wilson replied that CMS is very sensitive to ensuring that beneficiaries have continued access to services and that small suppliers have the opportunity to continue as suppliers. The agency currently has more than 100,000 suppliers. With regard to quality, CMS is concerned with the quality of both the goods provided and the related support services

(delivery, repair, etc). Contracts can be terminated if suppliers do not fulfill the terms. Because of the smaller number of suppliers in the DMEPOS program, CMS can do a more thorough job of oversight. .

CMS Response—Mr. Gutowski stated that CMS conducted two demonstration projects prior to the development of the original DMEPOS program that measured beneficiary satisfaction before and after competitive bidding programs and showed no discernible difference in perceived quality.

CMS Response—Mr. Wilson stated that CMS wants to have enough contract suppliers in the program to ensure they are competing with each other and offering quality goods and services. By phasing in the program, CMS can evaluate how things are going and adjust the program as needed.

Member Comment—Ms. Markwood asked if the exempted areas will be subject to measures to improve quality and service.

CMS Response—Mr. Wilson indicated that improving quality and service are part of a broader effort and are not limited to DMEPOS. The accreditation and quality standards, which started with the original DMEPOS program, are being implemented nationwide. The mechanisms that CMS is using to raise the bar for entry into the program, such as surety bonds and more frequent site visits, help keep unreliable or predatory suppliers out of the program.

Member Comment—Ms. Snead asked if there is any requirement for measuring access to supplies after the implementation of the accreditation standards. She expressed concerns that beneficiaries in rural areas will have difficulty accessing suppliers if current suppliers who only provide a few items annually decide not to participate because of the costs associated with acquiring a surety bond or meeting other accreditation standards.

CMS Response—Mr. Wilson replied that CMS is sensitive to this issue. Surety bonds will be required of all suppliers as of October 1. CMS is monitoring the effect of this, especially with regard to pharmacies and community suppliers. Surety bonds generally cost about \$1,500 and accreditation generally runs under \$2,500. CMS collects data from its accreditation agency weekly in order to see patterns and identify potential problems.

CMS Response—Mr. Gutowski promised to report back on the issues raised by panelists.

Public Comment

Rebecca Snead, APME Chair

There were no comments offered at this time.

Meeting Recap, Recommendations, and Next Steps

Rebecca Snead, APME Chair

Ms. Snead briefly reviewed the day's activities and indicated that the panel would begin forming subgroups to address selected topics.

Dr. Green indicated that she would like to have presentations in the future concerning cultural competence, health literacy, reducing and eliminating disparities, emerging threats, and issues associated with dual eligibles.

Ms. Snead announced that the next APME meeting will take place on October 22.

Communications with CMS resulting from this will be circulated to panelists for review.

Adjourn

Lynne G. Johnson, (DFO), CMS

Ms. Johnson adjourned the meeting.