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 729G
Washington DC 20201
Thursday, May 22, 2014

EXECUTIVE SUMMARY

Opening
Kirsten Knutson, Designated Federal Official, Office of Communications, CMS

Ms. Knutson called the meeting to order at 8:42 a.m. EDT. She thanked panelists and guests for attending and for their flexibility in dealing with weather exigencies of the past months. She noted that meeting in a federal building requires an authorized escort to move around the building.

Welcome
Sandy Markwood, APOE Chair
Julie Bataille, Director, CMS Office of Communications

Ms. Markwood welcomed panelists, noting that it had been some time since the previous APOE meeting in September 2013. Panelists introduced themselves and stated their affiliations. Panelist Jan Henning, of the North Central Texas Area Agency on Aging, was not present but joined the meeting by telephone later in the morning.

Ms. Bataille said this was Ms. Markwood's last APOE meeting and recognized her for her years of service to APOE and CMS with a certificate. Ms. Markwood said her 6 years on the panel have passed quickly and she has been inspired by the expertise and help of panel members.

CMS Response to APOE Recommendations from September 16, 2013 Meeting
Ms. Markwood
Ms. Bataille

The September 16, 2013 meeting prompted a large number of recommendations, Ms. Markwood said, and CMS concurred with almost all of them. She identified the recommendations and Ms. Bataille presented the responses.

The first topic was the Center for Program Integrity Update and Medicaid Integrity Provider Education; specifically how to ensure that Open Payments reporting and disclosure processes are complete, accurate, and clear and to educate consumers and stakeholders about how the payments can explain the relationships. The first recommendation was to conduct an educational campaign about the purpose and interpretation of Open Payments data, including publication of case studies, systematic organization of data that emphasizes financial relationships, incorporating the data into existing insurance enrollment processes, and consumer and/or

provider testing of the website. CMS agreed with the recommendation and continues to develop education and outreach materials about Open Payments.

APOE also recommended that CMS align the Open Payment process with currently existing reporting requirements to avoid redundancy and overburdening providers and health care systems. CMS agreed, but clarified that Open Payment does not require that physicians and teaching hospitals report to CMS. Only manufacturers and group purchasing organizations are required to report. Another APOE recommendation was to explain how existing federal laws interact with the transparency requirements. Ms. Bataille noted that Open Payments implements the requirements of section 6002 of the Affordable Care Act (ACA). Because providers and teaching hospitals are not required to report, they are not liable for penalties, but they are encouraged to report. CMS continues to develop guidance to clarify the program and its requirements and timeline, with a spring 2014 launch of the data submission portal, and data posted to the public website by September 30, 2014.

An additional four recommendations related to the goal to maximize awareness of the Medicaid Integrity Program (MIP) and the MIP educational tools and products among providers. The recommendations were to expand the MIP reach to medical support staff, professional organization members, ombudsman programs, and others; to ensure cultural and linguistic sensitivity in communicating with providers in minority communities; to exercise caution in applying penalties; and to ensure that the data collected recognize true service needs. CMS concurred with all four recommendations and appreciates the importance of the issues, Ms. Bataille said.

The next recommendations were about the Million Hearts Campaign to prevent heart attacks and strokes. The first recommendation was to align outreach, care coverage, and quality measures, and CMS agreed and included Million Hearts priorities in the 2014 call letter to Medicare Advantage and prescription drug benefit plans. CMS also agreed that Million Hearts can play a meaningful role in the Physician Quality Programs Management and Implementation effort to align federal and private programs, with much of the work in progress. The third Million Hearts recommendation was to include a standardized set of needs assessment conditions for all federal programs to align population health and effectiveness measures across all agencies, and CMS agreed on this approach and recently received a $2.7 million grant to align population health and effectiveness measures.

Another Million Hearts recommendation was to include ads or taglines in conjunction with Marketplace advertising, and CMS concurred. Other recommendations involved establishing networks to broaden and further the campaign, to work with other groups to use ACA outreach, to engage nontraditional providers and reach beyond health related stakeholders, to foster an intergenerational approach and target college students, to use smart phones and related technologies, and to engage other government agencies including the U.S. Department of Agriculture. CMS agreed with the recommendations, and Ms. Bataille noted that two key targets are in mind—beneficiaries and providers. CMS takes intergenerational outreach seriously and will work with sister agencies to share collateral materials to disseminate messages.

CMS did not concur with the Million Hearts recommendation to consider obtaining or re-directing funding for smoking cessation programs or making blood pressure measurement equipment available in community pharmacies. Million Hearts cannot directly fund these programs and other avenues exist to accomplish these goals, such as through Medicare Advantage, accountable care organizations, and the Medicaid Incentives for Prevention of Chronic Disease program.

In discussion of the recommendations, panelists expressed a need for more explicit instructions about Open Payments reporting, and Ms. Bataille said she would communicate that message to the program for implementation. Another concern was about the use of durable equipment for smoking cessation efforts in the Million Hearts program, with a question about why Medicaid cannot use the same evidence that Medicare did about how such equipment reduces burden of disease.

Listening Session—Marketplace Enrollment: Lessons Learned
Ms. Bataille

The outreach for Marketplace enrollment was a success, with more than 8 million people enrolled, a tremendous accomplishment and a testament to APOE members and their organizations and many others around the country who helped. Media efforts reached 95 percent of the target audience 41 times, and the digital effort was unprecedented. Facebook turned out to be an important channel. More than 67 million visits to healthcare.gov and 23 million calls to the call center shattered CMS expectations.

CMS learned that using multiple channels, including social media, drove enrollment. Another lesson was the importance of follow-up. Direct consumer communication was valuable, as were the feedback loop and engagement with partners. During the rollout and enrollment period, awareness of the Marketplace and website visits continued to grow.

It is important to not lose the momentum, and CMS will continue to consider messages that will resonate. Testimonials using real people and their stories have worked best. Commencement speeches, social media, and partnerships can educate newly graduated students on eligibility for the Marketplace. Ongoing outreach also will be directed at individuals experiencing job change.

CMS is building on lessons learned this year, and Ms. Bataille requested feedback from APOE panelists. Ms. Markwood said APOE appreciates the opportunity to be part of the dialogue.

Discussion of Marketplace Lessons Learned
APOE members

APOE members emphasized the importance of follow-up. Assisters could use more training on immediate post-enrollment follow-up with a more transparent feedback loop. A new paradigm for training assisters would be helpful. Also, the national materials provided were excellent, but local jurisdictions usually do not have the capability to customize the materials.

Panelists noted that it would be helpful to know what is possible and feasible, what can be fixed, and what cannot. For example, is it possible for call centers to have specialized expertise? In the current resource-constrained environment, is financial support possible for agencies? Ms. Bataille commented that CMS is considering how to make volunteers from community organizations available and how to work across agencies.

More data from CMS would be helpful. This was a continuing theme. For example, how many potential enrollees began applications but did not finish? How many needed help? What were the barriers to enrollment? Can they be stratified by age, rural/urban location, ethnicity, or other factors? This information can help adjust strategies. Local data also are needed.

Another question is how to best use resources. Plugging into annual conferences of various organizations might be a useful approach.

Ms. Markwood summarized that this is a phenomenal endeavor of important significance.

Recommendations (1)

Recommendations for the health insurance Marketplace included improving structure of call centers with better access for assisters and a defined pathway for complex questions and better training for assisters. Other recommendations were to share data about what worked and what didn't, investigate barriers, target students, educate providers, and educate individuals about how to be good health care consumers. Also, the APOE recommended coordinating media strategies, using testimonials to communicate messages, helping enrollees understand their pathways once they have coverage, and addressing problems of access to care.

Coverage to Care Pilot Program
Cara James, Ph.D., Director, Office of Minority Health, CMS

With 13 million Americans newly insured through the Marketplace and Medicaid and more aging into Medicare, challenges for the uninsured and the newly insured center around income issues, education, limited English proficiency, and the lack of a medical home. The Coverage to Care program aims to clarify what it means to have health insurance, how to find the right provider, when and where to seek health services, and why a medical home is important. It also seeks to equip providers and staff with information and resources to help them connect with the newly insured.

The first phase of Coverage to Care was an environmental scan to understand patients and engage providers and community stakeholders, followed by an engagement piloting strategy, which is now underway. The third phase will be pilot implementation and evaluation. The environmental scan indicated that the newly insured probably have low levels of insurance and health literacy, with a lack of understanding of the value of preventive services and routine care. Cultural and linguistic barriers exist between consumers and providers, along with historic barriers such as costs, lack of transportation, and inability to get time off work for medical care.

Phase II is building on existing networks in nine diverse communities in Arizona, California, Michigan, and Mississippi. CMS has developed materials that include a roadmap, video vignettes, and a website. The phase III evaluation will determine whether materials actually help people and define successful strategies. Initial feedback has noted the need for multiple language versions of the roadmap, an accessible reading level, and more prevention information. Another suggestion is to create apps for consumers to track their health behaviors. Dr. James encouraged APOE panelists to share the program's resources and feed back their suggestions. The roadmap will be revised based on feedback. National expansion is planned.

In discussion, panelists asked about engagement with local health departments, use of nontraditional means of communication, and the need for emergency rooms to change their behaviors and encourage patients to connect with primary care. Translations must be culturally and linguistically appropriate. Use of graphics and a modular approach could be helpful. Philip Bergquist, an APOE panelist who has been involved with the Michigan pilot program, said the materials should be modularized so that consumers are not faced with an overwhelming amount of information. The intensity of the Marketplace enrollment message can now be switched to access to care. Contacts could be through school programs, community groups, Medicaid managed plans, departments of social services, unemployment commissions, and professional organizations for providers, who also need incentives.

Social media can be a valuable tool, and a CMS partnership with a large phone company (e.g., Verizon) could be a useful approach. The program could converge with the Million Hearts campaign, which has a similar audience and a similar prevention message. Another important message is how to use health care resources wisely.

Recommendations (2)

For the Coverage to Care program, APOE panelists recommended development of training processes for assisters and navigators, emphasis on adaptations rather than word-for-word translations, local customization of materials, using vignettes in communication tools, and more integration with state Medicaid and CHIP programs. Other recommendations addressed intensifying the access message, use of phone apps, using the existing match process, packaging insurance cards with other related materials, using provider offices for patient education, and involving additional partners.

Provider, Beneficiary, and Family Engagement in Appropriate Use of Medicare Preventive Services

Joseph Chin, M.D., M.S., CMS Coverage & Analysis Group

Dr. Chin described how CMS approaches preventive services, with scenarios to inform providers and beneficiaries. Medicare did not originally cover preventive services but has added them through acts of Congress in 1997, 2003, 2008, and the 2010 ACA. Coverage is tied to A and B recommendations of the U.S. Preventive Services Task Force (USPSTF). The ACA also mandates coverage of an annual wellness visit, which includes a number of required elements.

USPSTF recommendations and Medicare coverage are not always in accord, which can lead to confusion. For example, the USPSTF does not recommend screening for colorectal cancer for individuals older than 86 years of age, but Medicare covers testing for life. USPSTF recommendations are often tiered by age, while Medicare does not stratify by age. This raises the question of how to best communicate with and educate providers and beneficiaries about preventive services without discouraging the use of preventive services.

Coverage of preventive services also can differ between health plans, private insurers, and Medicare, raising the question of how to best educate beneficiaries and their families about the differences and changes when transitioning into Medicare. Sometimes news reports about preventive coverage are inaccurate.

The annual wellness visit requires detection of any cognitive impairment, although several recent reports have questioned the value of the requirement, and it is not in concordance with the USPSTF statement of insufficient evidence about cognitive impairment. This leads to the question of how best to timely communicate with providers, beneficiaries, and their families about potentially misleading information.

In a far-ranging discussion, panelists considered CMS response to misinformation; the distinction between screening and diagnosis; the value of screening; and the utility of the annual wellness visit, which has narrow parameters and is not an actual checkup or preventive health visit. Primary prevention involves asymptomatic patients, but few Medicare patients are completely asymptomatic. The communications problems are large, and reporters are another group that needs education. Letters to the editor require agency clearance, which makes timeliness difficult. Using surrogates (e.g., professional societies) could be a more nimble approach.

Materials about the annual wellness visit are online, and there have been online courses for providers and office staff. Beyond information, a practice shift is needed. This could be achieved by incentivizing providers with meaningful use dollars and aligning electronic health records with the requirements. CMS also could explore other guidelines such as those developed by the American Heart Association, American Diabetes Association, and American Cancer Society.

A diagram of steps to transition to Medicare, with a listing of changes from other coverage, could be helpful. Dr. Chin was not aware whether there are existing outreach efforts to caregivers.

Recommendations (3)

Panelists proposed four prioritized recommendations: 1) to develop a rapid response strategy with the CMS Office of Communications; 2) to enlist the help of partner organizations; 3) to begin an education campaign with the press, including contact information with experts; and 4) to strongly reinforce communications about the importance of a medical home.

Other recommendations addressed the need for sensitivity about health literacy and plainly stating facts about benefits, the need for both a proactive and reactive communications strategy,

resource allocation, communication with providers, understanding the consumer perspective of the wellness visit, explaining the rationale about different age thresholds for various screening tests, and how the gaps between USPSTF and Congressional mandates for Medicare can be bridged.

Public Comment
Ms. Markwood

Mindy McGrath, of the National Family Planning and Reproductive Health Association (NFPRHA), described her group's outreach and enrollment efforts and stated the ongoing need for insurance enrollment support. One NFPRHA initiative is for the CMS Center for Consumer Information & Insurance Oversight to encourage qualified health plans to credential nurses for the services they are licensed to provide.

Theresa Morgan of the Habilitation Benefit Coalition urged that habilitation benefits be covered more fairly. It can be hard to know whether a plan being purchased has the necessary services, which are mandated by the ACA. She asked for the help of the APOE to advise CMS about what communications materials might be necessary.

Recap of Meeting and Final Comments
Miriam Mobley-Smith, Pharm.D., APOE co-chair
Ms. Markwood

Dr. Mobley-Smith summarized the meeting. Ms. Markwood said she and Dr. Mobley-Smith will work with Ms. Knutson to refine the recommendations, and panelists can expect them for review in 2 weeks. The goal is to submit finalized recommendations to CMS within 4 weeks.

Ms. Markwood thanked APOE panelists for the privilege of chairing the group.

Suggestions for topics to consider at upcoming meetings were the training environment for healthcare.gov, renewal of coverage through the Marketplace, and how more data about the Marketplace can be made available.

Adjournment

Ms. Knutson adjourned the meeting at 3:07 p.m. EDT.