

EXECUTIVE SUMMARY

In-Person Meeting of the Advisory Panel on Outreach and Education (APOE)

SEPTEMBER 19, 2024, 9:06 A.M.–3:06 P.M. EDT

Open Meeting

Walter Gutowski, Designated Federal Official (DFO), Senior Advisor, Partner Relations Group (PRG), Office of Communications (OC), Centers for Medicare & Medicaid Services (CMS)

Mr. Gutowski opened the meeting at 9:05 a.m. EDT, introduced himself as the Designated Federal Official (DFO), and reviewed housekeeping items to ensure compliance with the Federal Advisory Committee Act (FACA). He reminded APOE members to speak into the microphones so that all comments could be captured. He announced that APOE would hear public comments at the end of the meeting, noting that the time is set aside for comments only and that any person wishing to give public comment should sign up at the registration desk. Finally, he announced that in compliance with a White House directive, any lobbyists should identify themselves as such before speaking.

Welcome and Opening Comments

Stefanie Costello, Director, PRG, OC, CMS

Ms. Costello thanked the APOE members for joining the meeting and previewed the agenda. She introduced Neil Meltzer as the APOE Chair.

Opening Comments and Panel Introductions

Neil Meltzer, APOE Chair

Mr. Meltzer welcomed attendees and reminded them that this is an open meeting and everything said is on the record. He stated that the opinions expressed by panel members are their individual opinions and do not necessarily reflect the views of the organizations with which they are affiliated. Mr. Meltzer conducted a roll call. After each member introduced themselves, he turned the meeting over to Ms. Costello.

CMS Response to APOE Recommendations

Stefanie Costello, Director, PRG, OC, CMS

Ms. Costello informed APOE members that CMS' response to APOE's recommendations from the April 18, 2024 meeting was included in the meeting packet. APOE members did not have any questions. Ms. Costello turned the meeting back to Mr. Meltzer to introduce the first speaker.

Oral Health Advancements: Update from the Centers for Medicare & Medicaid Services

Natalia I. Chalmers, DDS, MHSc, PhD, Chief Dental Officer, Office of the Administrator, CMS

Dr. Chalmers updated APOE on changes to oral health coverage that are happening in CMS. CMS ensures that 156.6 million people in the United States have health coverage through Medicaid and the Children's Health Insurance Program (CHIP), Medicare, and the Marketplace, but oral health care coverage varies between the programs. For example, in the Marketplace, oral health care is essential coverage for children but not for adults. Disparities also persist outside of CMS: in 2016, 58.3% of children above 400% of the federal poverty guideline (FPG) have had at least one dental visit compared to 38.4% below the FPG, and 61.3% of seniors above 400% of the FPG have had at least one dental visit compared to 24.4% of seniors below the FPG. It is much more expensive to address oral health as part of an emergency room visit versus recurring dentist visits.

Concerning Medicaid and CHIP, Dr. Chalmers reported that coverage drastically varies by state. As of July 2022, the percentage of the child population enrolled in Medicaid or CHIP for each state ranged from 25.1% to 82.5% of the population, and the percentage of the adult population enrolled ranged from 6% to 34.4% of the population. Due to the vast coverage differences, there are essentially 58 separate programs.

CMS created an Advancing Oral Health Prevention in Primary Care Affinity Group with 14 participating states that had the primary objective of supporting states in developing sustainable solutions for improving the delivery of fluoride varnish (FV) by primary care physicians enrolled in Medicaid and CHIP. During the two years of the affinity group, state teams received technical assistance on the Model for Improvement. Each state team designed, tested, implemented, and assessed its own quality improvement project to improve FV application rates in primary care. Many teams used the Topical Fluoride for Children measure to monitor changes in the delivery of FV.

With respect to Medicare, Dr. Chalmers presented statistics concerning disparities in oral health care for Medicare beneficiaries. In 2019, 47.9% of White non-Hispanic beneficiaries had at least one dental examination compared to 17.9% of Black non-Hispanic beneficiaries, and 21.9% of beneficiaries with incomes less than \$10,000 annually had at least one dental examination compared to 61% of beneficiaries with income greater than or equal to \$50,000.

Dr. Chalmers explained that section 1862(a)(12) of the Social Security Act generally prohibits payment from Medicare for most dental expenses unless there is an underlying medical condition or a severe clinical status. In 2023, CMS finalized a regulation that clarified that Medicare would pay for dental services that are inextricably linked to other covered medical services, such as dental exams and necessary treatments prior to organ transplants, cardiac valve replacements, and valvuloplasty procedures, and for dental exams and necessary treatments prior to the treatment for head and neck cancers.

For 2024, Dr. Chalmers explained that a proposed regulation would allow Medicare to pay for dental services in connection with head and neck cancer treatments, whether primary or metastatic; as part of a comprehensive workup prior to medically necessary diagnostic and treatment services, to eliminate an oral or dental infection prior to, or contemporaneously with, those treatment services, and to address dental or oral complications after radiation, chemotherapy, and/or surgery when used in the treatment of head and neck cancer; and for dental services inextricably linked to other covered services used to treat cancer, including

chemotherapy services, Chimeric Antigen Receptor T Cell therapy, and the antiresorptive therapy.

Dr. Chalmers stated that, as of July 1, 2024, CMS can officially accept electronic 837D dental claims, which is a big milestone. For many dentists, this will be their first time becoming a Medicare provider, so CMS will have to educate them on the process.

Concerning the Marketplace, Dr. Chalmers announced that starting January 1, 2027, CMS will allow states to add routine adult dental services as an essential health benefit to Marketplace plans.

Discussion of Recommendations Among APOE Members and Dr. Chalmers

APOE members discussed outreach strategies to educate both dental and non-dental providers about Medicare dental services. Recommendations begin with using a system, similar to MDCalc, that allows a clinician to search what would be covered. Also, to learn from the Dental Service Foundation's efforts to connect dental and primary care providers in Washington State. And to work with dental, trade, and Medicare advocacy associations, such as the American Dental Association, the Dental Trade Alliance, and the Medicare Oral Health Coalition. Other options include working with organizations whose missions concern chronic diseases that lead to transplants (e.g., the Kidney Foundation) and organizations that create clinical practice guidelines. APOE members suggested collaborating with case managers, community health workers, dietitians, emergency room physicians, and caregivers, each of whom are important patient care team members. And lastly, to educate health systems, community health centers, and State Health Insurance Assistance Programs (SHIPs) on the new rules.

Next, APOE members discussed the best methods to communicate these strategies to dental and non-dental providers. The panel proposed building scripts, templates, and best practice advisories into electronic health record systems to remind providers to make dental referrals. CMS should give clarity on confusing terms such as "inextricably linked" in the final rule and create lesson plans for dental and medical schools. Other panel suggestions included working with medical social media influencers to share messages, along with targeting educational materials for dental providers so that they can be educated on how to become credentialed in the CMS systems and submit claims and forms.

Finally, APOE members discussed how CMS can best educate medical providers about Medicare dental services linked to certain covered treatments. The panel noted that people are on transplant waitlists for a long time, creating an opportunity to let them know that completing tasks like oral health care can ensure better outcomes for their surgery. And educate people with bulletins and during grand rounds.

Empowering Beneficiaries & Caregivers: Medicare Covered Services for Substance Use Disorders

Thomas Bane, Special Assistant to the New York Regional Administrator, CMS Office of Program Operations and Local Engagement (OPOLE)

Mr. Bane explained that one of the main tasks of the regional office is to partner with OC on outreach. The regional office conducts outreach activities such as rural road trips, power hours, and conference speeches. OPOLE wants to hear recommendations for how the office can engage populations with opioid use disorder (OUD) and substance use disorder (SUD). Opioid-related overdose deaths in the United States remain a concern, with an estimated 82,310 deaths in 2021. OUD is a chronic disease that can be treated with medications such as

buprenorphine, methadone, and naltrexone—the combination of medication use with behavioral therapy is referred to as medication-assisted treatment (MAT).

Discussion of Recommendations Among APOE Members and Mr. Bane

APOE members discussed how to combat caregiver, provider, and beneficiary stigma associated with SUD/OD. Several suggestions were made beginning with using person-first language to destigmatize and needing to talk about this in a way that will not add to the problem. Also, there is a need to combat the MAT misinformation that affects patients; the misinformation increases resistance to gold-standard medications. Showing how addiction affects the brain and how the brain affects addiction—the science and biology behind addictions help to destigmatize. Storytelling from people receiving treatment helps destigmatize. Spend ample time recruiting storytellers because there is also a stigma where people do not want to publicly admit to receiving MAT. Additionally, how clinicians document OUD and SUD can also increase stigma. Telehealth and mail prescriptions can help destigmatize in areas with smaller populations so that, for example, the local pharmacy in town does not have to know that you are receiving MAT. Creating messaging for people to volunteer to serve other individuals will assist this initiative.

Next, APOE members discussed how to better raise awareness of SUD/OD-covered services among beneficiaries (and family caregivers) that are most in need of them. It will be beneficial to provide information about insurance coverage and the out-of-pocket cost of the MAT medications. And to provide information about where and how to access services along with how to bring up this topic with your provider.

APOE members discussed innovative partnerships that could be leveraged to carry this message as trusted sources of information beyond provider networks. Panel recommendations included leveraging the SUD partnerships that state governments have created. First Choice Services in West Virginia is a good example of a one-stop shop for integrated SUD/OD services. The members highlighted the benefit of seeking partnerships with Community Health Centers, Federally Qualified Health Centers, and Community Mental Health Centers. The Rush University Echo Program is a beneficial resource. Consider the employers and employee assistance programs (EAP) of loved ones as messengers to increase dialogue that is confidential and trusted. Also, encourage working with behavioral health provider associations, such as the American Counseling Association, NAADAC, the National Association of Social Workers, and Mental Health America. Collaborate with associations addressing chronic conditions; people may need help coming off opioids after pain treatment. Partner with trade associations to reach individuals who may become addicted to opioids after a workplace injury. And partner with Area Agencies on Aging (AAAs) and other groups that can tailor messaging to older populations. Alcoholics Anonymous has done a good job at overcoming stigma, aided by storytelling through Hollywood and the media. Engage philanthropy organizations to do more to address these issues and to serve as thought partners in addressing these questions (e.g., Arnold Ventures), as well as Veterans' groups and the Veterans Administration which can reach older veterans.

APOE members discussed the materials and mediums that could be most effective for sharing SUD/OD messages. Beginning with extending the relaxed eligibility criteria to receive the Addiction Medicine Physician designation and to use social media influencers for different ages and subgroups/subcultures. Also, target online advertisements for people who are searching for SUD resources and conduct guerilla marketing to go where people are. Expand the availability of mental health services in multiple languages to ensure that non-English speaking populations have access to care while also leveraging nutrition messaging (add "other healthy living"

messaging to the “eating healthy” message). Remember that with storytelling, be mindful of messaging surrounding relapses.

Finally, APOE members discussed how to best integrate health equity into these efforts. Investigate using an artificial intelligence system that allows patients to ask questions to help lead to potential treatment options and locations. Extend the telehealth ability for physicians to provide OUD/SUD services (it expires in December 2024). And work with elder care providers, as they could have less stigma than a facility that specializes in SUD reduction. Awareness to combat generalizations and stereotypes about who uses opioids is needed as well. Target messaging for children of family members with SUD, as sometimes they serve in a caregiving role for their parents and guardians. It would be innovative if people could self-refer for services, especially if this could be available online.

Streamlining Medicare Savings Program Eligibility and Enrollment

Tim Engelhardt, Director, CMS Medicare-Medicaid Coordination Office

Mr. Engelhardt explained that his office focuses on the 12 million individuals who are dually eligible for both Medicare and Medicaid. Medicare Savings Programs (MSPs) are Medicaid eligibility groups through which states cover certain Medicare costs. More than 10 million people are enrolled in MSPs, but many eligible people are not enrolled. Some of the reasons for this include stigma about receiving assistance, not understanding program details, and some policies creating administrative burdens and barriers to enrollment and retention of eligible individuals.

CMS finalized a regulation to assist with enrollment in MSPs. Under this regulation, as of October 1, 2024, states must automatically deem most Medicare-enrolled SSI recipients eligible for QMB (the Qualified Medicare Beneficiary Program), and by April 1, 2026, states must have procedures in place to treat Extra Help leads data as an application for MSP and determine MSP eligibility promptly, including accepting self-attestation for some missing application pieces. Further, states will be required to use a more standard definition for family size. CMS estimates that this regulation will eliminate 19 million hours of paperwork burden for applicants and 2 million hours of paperwork burden for state government employees.

Mr. Engelhardt previewed different considerations when communicating about these changes. First, the terminology between the various programs providing financial assistance can be similar and/or confusing to beneficiaries. Second, there is a conflation with prevalent television ads for brokers seeking profit for helping individuals receive these benefits. Finally, nationwide eligibility messaging is difficult due to each state having different program eligibility policies.

Discussion of Recommendations Among APOE Members and Mr. Engelhardt

APOE members discussed how CMS can best promote the MSPs, especially relative to promoting other forms of coverage and Medicare subsidy programs. Recommendations included creating a partnership between Medicaid and Medicare to ensure that individuals are referred to receive all benefits for which they are eligible. Be mindful that individuals do not always have full awareness of the income information required for an application that takes 20 minutes to complete. Use a national verification portal built on Medicaid data with application status tracking to ease the application burden. Understand that word of mouth from program participants is important, especially if they have a good story to tell about the ease of the application process. Meet potential beneficiaries where they are when they seek help. For example, have resources available for help centers and nursing homes. Create webinars and frequently asked questions (FAQs) that walk

people through the process. Consider condensing the information down to a webinar similar to the Marketplace Navigator training.

Promote MSPs as a coupon/way to save money instead of a “handout” and also create an online savings calculator to show the potential savings of MSP enrollment. Additionally, coordinate with the Social Security Administration, the administrator of Extra Help, because there is eligibility similarity in the population served. Also, promote using universal language amongst the states. Lastly, ensure funding for eligibility assistance is included in the budget.

Next, APOE members discussed which community partners can most effectively educate individuals about the MSPs. The panel’s recommendations included: SHIPs and AAAs, Community Action Agencies, The National Urban League, NAACP chapters, financial counselors (including hospitals with charity care applications), pharmacies, community health workers, UnidosUS and its affiliates, Case Management Society of America, Catholic Charities, food banks, libraries, AARP, television ads with a popular actor, Marketplace Navigators (Marketplace), insurance brokers and disability advocacy groups.

Finally, APOE members discussed what strategies CMS should deploy to reach communities less likely to consume traditional mass media. Suggestions included using Facebook groups and advertisements, partnering with language access organizations, conducting text messaging campaigns, and working with community and affinity groups—there is a trust there that is different than traditional and social media. Other ways to deploy the messaging are through pharmacists, collaborating with faith-based organizations (e.g., the National Association of Black Churches), working with Meals on Wheels, and placing stories and advertisements in ethnic newspapers. Also, placing advertisements on public transportation vehicles and bus stops was discussed, promoting word of mouth with current MSP recipients and adding information to mailers or on explanations of benefits. Lastly, coordinating with the IRS and tax preparers to identify potentially eligible people, perhaps including a mailer to the taxpayer could be a vital way to communicate and to study and implement the lessons learned from the Medicaid unwinding process.

Fraud Prevention

Stefanie Costello, Director, PRG, OC, CMS

Ms. Costello presented CMS’ efforts to communicate about fraud prevention. CMS defines fraud as when someone knowingly deceives, conceals, or misrepresents to obtain money or property from any health care benefit program. Examples of fraud include CMS being billed for services never rendered, editing a document to receive a higher payment, or someone else using a beneficiary’s Medicare or Medicaid card. In a recent fraud case, a company was billing CMS for hospice care for individuals who were not eligible for hospice; OC made social media posts and drop-in articles to educate the public about this example in a quick turnaround strategy.

Ms. Costello summarized the Guard Your Card campaign. The campaign reminds beneficiaries to protect their Medicare number with the same level of caution as their Social Security number, to guard their Medicare card like it is a credit card, and to remember that Medicare will never call to sell products and will only ask for personal information in limited situations. Further, the campaign reminds beneficiaries not to accept gifts for free medical care and not to join a Medicare health or drug plan over the phone unless the beneficiary initiates the phone call.

Discussion of Recommendations Among APOE Members and Ms. Costello

APOE members discussed how CMS can educate Medicare beneficiaries about potential fraud related to healthcare services, products, and equipment, and what vehicles help carry this message. CMS can continue using social media platforms, including those commonly used by immigrant communities (such as WhatsApp messages), and increase outreach. It is hard to balance the interests of legitimate assistance versus scammers. Having too much messaging around fraud might inadvertently help scammers come across as more legitimate. Include short, focused fraud alerts as inserts to existing CMS mailings. Leverage trusted partners like AARP, pharmacies, and local community groups (e.g., places of worship, assisted living facilities, state insurance commissioners, etc.) to spread fraud prevention messages. Create a mark (brand) or other method to distinguish legitimate government mail pieces from managed care advertisements. Also, educate about how to receive a replacement card or a card number if yours becomes compromised. The messaging should not blame the victim but instead focus on the support that CMS can provide. Facebook groups and pages (e.g., from police departments) are a helpful and legitimate medium for receiving information. A whistleblowing program can be created where people receive a percentage of the funds recovered through the prosecution of the case. Also, inform hospice providers of their liability if they are caught providing ineligible or fraudulent hospice care. We can learn best practices from those who combat identity theft.

Next, APOE members discussed the pros and cons of reaching beneficiaries about fraud through various tactics. In-person tactics, events with trusted community partners, and tabling at their professional locations can be helpful ways to reach beneficiaries and providers. There is difficulty exploring phone tactics because there is other messaging about how CMS will not proactively call beneficiaries. Consider updating phone scripts to ask people how they knew to call the hotline to report fraud.

Finally, APOE members discussed what trusted voices CMS should engage with to share fraud messaging with beneficiaries and if there are specific times of year that the beneficiaries might pay more attention to fraud messaging. Suggestions included AARP, storytelling from a recent fraud victim which would be impactful and ensuring that training is updated with recent fraud examples. Open enrollment periods are periods when people are receptive to CMS messaging. Also, the local news can generate stories about fraud to educate and deter. Since a lot of fraud occurs during holiday seasons with gift purchasing and giving (e.g., from Black Friday through New Year's Eve), messaging can be more frequent during those times. Additional platforms for messaging are pharmacists, regional radio ads, and public service announcements, and collaborating with the Medicare provider network, churches, and assisted living facilities.

Public Comment

Neil Meltzer, APOE Chair

Mr. Meltzer opened the floor for public comment, but there were no comments.

Final Comments

Neil Meltzer, APOE Chair

Mr. Meltzer stated that the next APOE meeting is scheduled to be held virtually on February 6, 2025.

Meeting Adjournment

Walter Gutowski, DFO, Senior Advisor, PRG, OC, CMS

Mr. Gutowski adjourned the meeting at 3:06 p.m. EDT. The next APOE meeting will be announced in the Federal Register.