

**Meeting of the Advisory Panel on Outreach and Education (APOE)  
Centers for Medicare & Medicaid Services (CMS)**

**Virtual Meeting  
July 28, 2021**

**EXECUTIVE SUMMARY**

**Open Meeting**

*Lisa Carr, Designated Federal Official (DFO), Partner Relations Group, Office of Communications (OC), CMS*

Ms. Carr called the virtual meeting to order at 12:07 p.m. She welcomed all participants and noted that she serves as the Designated Federal Official (DFO) to ensure compliance with the Federal Advisory Committee Act (FACA). In compliance with a White House directive, she asked all lobbyists to identify themselves as lobbyists before speaking. Ms. Carr introduced Ms. Stefanie Costello.

**Welcome and Opening Comments**

*Stefanie Costello, Director, CMS Partner Relations Group*

Ms. Costello thanked participants for joining, noted the four items on the agenda—Engaging Employers for Medicare Enrollment, The Medicare.gov Homepage & Landing Pages, Tribal Enrollment in CMS Programs, and Minimizing Beneficiary Churn in Medicaid—and turned the meeting over to Dr. Margot Savoy, APOE Chair.

**Opening Comments and Panel Introductions**

*Dr. Margot Savoy, APOE Chair*

*Ms. Cheri Lattimer, APOE Vice-Chair*

Dr. Savoy thanked participants for attending. She reminded participants that the meeting is open to the press and the public, and added that the opinions expressed by the panelists are those of the individuals and not the organizations with which they are associated.

Dr. Savoy noted that Lorraine Bell was not able to attend the meeting, and asked the members of the panel to introduce themselves.

**CMS Response to APOE Recommendations from the May 26, 2021 Meeting**

*Stefanie Costello, Director, CMS Partner Relations Group*

Ms. Costello informed participants that the recommendations from the May 26, 2021 meeting were included in the meeting packets, and turned the meeting back to Dr. Savoy.

## **Engaging Employers for Medicare Enrollment**

***Katherine McDowell, Regional Administrator, CMS Boston***

Ms. McDowell addressed CMS's efforts through the Office of Program Operations & Local Engagement (OPOLE) to effectively engage with employers on outreach to individuals approaching Medicare enrollment eligibility.

CMS's research shows consumers believe Medicare is confusing and complicated. To alleviate consumers' stress as they transition to Medicare, CMS's Local Engagement and Administration (LEA) is focused on educating consumers earlier in the process. While LEA has been focused on community-based education and educating community advocates, it has not focused on targeted outreach to employers that provides an opportunity to reach a large portion of the 10,000 people who turn 65 each day.

On a national level, CMS headquarters attempted to work with the Society for Human Resource Management (SHRM) on this issue. Regionally, LEA has worked with large employers to get information to retirees directly. Since 2019, LEA has held 23 events directed at employers. Prior to 2014 when the Affordable Care Act first rolled out, CMS focused on the Small Business Health Options (SHOP) program through 187 partners. Without a targeted approach focused on employers, CMS is dependent on local outreach, which leads to inconsistency in messaging. However, educating employers on Medicare enrollment provides an opportunity for employers to educate their retirees and replicate the message multiple times.

The more than 16,000 large employers with more than 500 employees have a captive audience in need of Medicare enrollment information. About 29 percent of large employers offer retiree health coverage, which is secondary to Medicare. Providing explanations on the Medicare program and how it works alongside the employers' health coverage can ease questions for retirees.

While traditional engagement with employers can work, CMS's biggest challenges are finding the right employer contact and convincing the employer contact of the benefit of educating their employees.

## **Discussion of Recommendations among APOE Members and Ms. McDowell**

Following the discussion, the panel made a series of preliminary recommendations, including outreach to associations such as SHRM and State Health Insurance Assistance Programs (SHIP), Chambers of Commerce, community-based organizations, local and federal governments, AARP and business groups; attendance at community-based health fairs; coordination with the Social Security Administration to send messages to people nearing retirement age; and outreach to unions, which often provide employee health insurance programs. The panel recommended distributing readymade material via the Small Business Administration and Chambers of Commerce that provides information by state or county to employees (e.g., a toolkit, companion grid); contacting insurance companies that conduct health fairs or community events about

appearing at the events; and considering the example of Healthier Tennessee, Healthy Memphis and Healthy Chattanooga that have monthly meetings with employers.

The panel further recommended CMS provide information about coordinating Medicare benefits with COBRA; clarify education around the pros and cons of using Medicare vs. COBRA during the transition period; ensure employers are protected through equitable relief; consider traditional and digital programs such as a “Welcome to Medicare” video on YouTube; provide information that can streamline the process for HR employees to educate consumers; maintain the consumer-centric focus by using simple, user friendly language; emulate material provided to employees during the open enrollment process, make the information more consistent with the material employees receive about HMOs and other benefits; consider programs employers use to help employees transition to retirement (e.g., “Road Next Traveled” for employees within 3-7 years of retirement); use basic enrollment information from the “Medicare and You Handbook”; and make a shortened version of the handbook available to employers. The panel also recommended that CMS send more information to beneficiaries earlier than is done now; make written materials available in the workplace and ensure employees understand the decision-making timeline; make information available to anyone so that adult children can help their aging parents access it; and conduct a forum with major business leaders and large employers, perhaps including a Member of Congress as a panelist to help raise awareness.

The panel recommended delinking the Social Security and CMS connection to address the age disconnect between enrolling in Medicare and Social Security; explaining that Medicare is insurance and not a social program; partnering with insurers to improve transition to Medicare coverage; improving health insurance literacy to help employees understand insurance plans; and considering plug and play learning modules that target employees by age.

In addition, the panel said it was important for employers to know that decisions on enrolling in Medicare can and will affect employees’ Medicare for the rest of their lives. It noted some employers may be more interested and eager to share information with employees if they have information they understand, and suggested CMS consider certification or a special training for employers. The panel recommended CMS consider a designated liaison or dedicated hotline at CMS for employers to obtain additional information, get answers to questions, stay informed about the changing rules, and help HR departments understand that rules are different depending on the size of employer. They also suggested that CMS consider more education and support for the military community as some families have members that are eligible for TICARE and Medicare

### **The Medicare.gov Homepage & Landing Pages**

*Raven Nary, Health Insurance Specialist, Division of Content Development, Creative Services Group, CMS*

Ms. Nary discussed CMS’s initiative to improve the user experience of Medicare.gov. CMS is currently focused on creating a new homepage and landing page, with the goal to make the pages

welcoming, balance user needs and comfort with requirements, prioritize the users' top tasks, and make it easy for users to find the information they need.

### **Discussion of Recommendations among APOE Members and Ms. Narv**

The panel recommended CMS consider using responsive design, including chat mechanisms or chatbots to help users find solutions without abandoning their search; using an audience message design document and being clear about the real audience of the website; building in features that take advantage of modern-day accessibility to ensure that the website goes beyond meeting the ADA recommendations (e.g., tools for people with ADHD, addressing cognitive and vision issues); and addressing the font, color, and readability of the website. The panel also recommended adding graphics to internal landing pages to assist consumers with low or limited reading ability navigate the site, and creating a landing page that gives clear direction, groups information, and allows users to navigate to the information they want.

The panel recommended CMS conduct focus groups with elderly users to ensure those users can use the website. The suggestion was made that CMS contact organizations whose constituents are older adults, such as the AARP and the Alzheimer's Association, and talk to the organization's web designers about their approach and emulate them. In addition, the panel recommended CMS consider technology literacy and use information gleaned from focus groups to drive web page design (e.g., the top five reasons consumers visit the web page should be a prominent part of the landing page); consider making the link to translate information to other languages more prominent; consider how frequently CMS changes the home page; consider creating a similar look to HealthCare.gov; and add a countdown clock to open enrollment season. The panel suggested that the webpage include questions people ask the most in a set of frequently asked questions; consider that some users may be scared away by the request for an email that pops up as they visit the site; provide an option for providers and beneficiaries to input data to receive formulary information; consider the type and complexity of information on the landing page; provide a better whole picture of coverage to include information about MediGap; and consider an approach that caters to the least informed person.

The panel further recommended that CMS consider pop-up boxes that allow consumers to navigate the site; include more pictures; consider how easily consumers can share information with others (e.g., include Bitly links or use short URLs); review the accuracy of provider information, offer an opportunity for providers to opt in and provide the profile information the website shares; make a distinction between returning users and new users, including adding a feature to save "where you are" in the search so consumers can return at a later time; consider how non-members, such as counselors advising a beneficiary, can get information for a Medicare consumer; offer translations to additional languages; explain the two ways customers can get Medicare benefits; and add a toll-free number for state SHIP offices.

### **Tribal Enrollment in CMS Programs**

*Kitty Marx, Director, Division of Tribal Affairs, Children's and Adult Programs Group, Center for Medicaid and CHIP Services, CMS*

Ms. Marx discussed CMS's role supporting the health care of American Indians and Alaska Natives. The Division of Tribal Affairs serves as the point of contact for Indian health issues for CMS, and provides technical assistance on policy and reimbursement issues as well as outreach and education to support and increase the number of American Indians and Alaska Natives who are eligible for, but not enrolled in Medicare, Medicaid, CHIP and the Marketplace.

Of the nearly 5.5 million American Indians and Alaska Natives in the United States, the Indian Health Service (IHS) provides services to 2.6 million located in 37 states, most of whom are west of the Mississippi. The IHS operates hospitals and health centers. Enrollment in the various programs for American Indians and Alaska Natives is important because Medicare and Medicaid reimbursements help support the IHS and the tribal delivery system, and enrollment provides access to services that IHS and tribal hospitals might not be able to provide.

Regarding health disparities, American Indians and Alaska Natives have lower life expectancies, poorer health conditions, and a higher disease burden than other populations. The life expectancy for American Indians and Alaska Natives is 5.5 years less compared to other populations, and there are still higher rates of death for American Indians/Alaska Natives from alcoholism, diabetes, and other incidents, such as assault or homicide.

A large portion of the Division of Tribal Affairs' work is focused on outreach and education, including the development of fact sheets and brochures, delivery of trainings for IHS, and the production of monthly public service announcements that are played on tribal radio stations, published in tribal newspapers, and translated into 10 Native languages. For example, in July 2019, the Division of Tribal Affairs worked with IHS to promote local tribal health centers as a trusted source of care. Similar to other communities across the country, the IHS and many tribal programs experienced a significant decrease in their Medicare and Medicaid reimbursements during COVID because consumers were not visiting health centers.

Another outreach example is the public service announcement in newspapers and on radio stations to promote the Special Enrollment Period in the Marketplace. Enrollment in the Marketplace for American Indians and Alaska Natives has been challenging, with annual enrollment numbers of about 40,000 American Indians. As of July 1, 2021, 7,200 American Indians/Alaska Natives have taken advantage of the Special Enrollment Period. Tribal members can enroll in the Marketplace all year round, and CMS has been encouraging tribal members to take advantage of the current Special Enrollment Period option. IHS and tribal clinics can download and use all of the public service announcements, either by printing them or playing the announcements in clinic waiting rooms.

Since February 2021, the number of tribal members enrolling has increased significantly. Under the Affordable Care Act, tribal members who fall between 100 and 300 percent of the federal poverty level can either sign up for a zero cost-sharing plan with no copayments or deductibles or a limited cost-sharing plan with no copayments or deductibles if they have a referral from their Indian Healthcare plan and receive services from qualified health plans.

Over the past year, a significant portion of the Division of Tribal Affairs' work has involved support of the IHS and HHS distribution of information about the availability of the COVID-19 vaccines. The IHS has done incredible work in vaccinating the tribal members and other patients in the tribal communities. As of July 1, 2021, more than 1.4 million vaccines had been administered at over 350 IHS programs, and over 55 percent of the American Indian and Alaska Native patients have received at least one vaccine dose. Tribal communities promoted the availability of the vaccine with advertisements using tribal graphics and American Indian and Alaska Native people. On a local level, tribes have had success with communications that use their tribal chairmen, respected elders and tribal textiles in advertisements

### **Discussion of Recommendations among APOE Members and Ms. Marx**

The panel made a series of preliminary recommendations, including communicating the importance of tribal members signing up for Medicaid and noting that their participation protects IHS funding which is discretionary; coordinating with SHIPs to share information with elders; coordinating with the Administration for Community Living Title VI program to help enroll consumers; considering educational materials that addresses Medicaid as an add-on to existing coverage, rather than "either/or" coverage.

The panel further recommended forming partnerships with community health centers that received funding under the ACA to conduct outreach as well as partner with organizations that may get funding through Navigator grants, and use community health center outreach efforts as a model for CMS's outreach and enrollment. In addition, the panel recommended CMS consider an infographic with a personal care toolbox that allows consumers to build a plan and see the services of IHS enhanced with Medicaid; consider outreach to Native Americans who live in urban areas, particularly through community organizations that may not be focused solely on Native Americans; consider non-written communication, including videos using credible storytellers who can discuss the benefits of enrollment; ensure CMS's social media presence includes Native American representation rather than generic information; offer messages in tribal languages, which is especially important for elder members; and create infographics and messaging that address multiple diseases and conditions.

To increase COVID-19 vaccinations, the panel recommended CMS develop podcasts and more educational resources to teach providers how to deliver messaging to vaccine-hesitant consumers; ensure a social worker or case manager/community health worker from the Native American community with motivational interviewing skills is available at the time of the clinic to provide answers in real time; and leverage the FDA's full approval of the COVID-19 vaccines to remarket vaccines to CMS's target audiences.

### **Minimizing Beneficiary Churn as States Return to Normal Medicaid & CHIP Operations after the COVID-19 Public Health Emergency (PHE)**

*Jessica Stephens, Director, Division of Enrollment Policy and Operations, Center for Medicaid and CHIP Services, CMS*

Ms. Stephens discussed the anticipated challenges in Medicaid enrollment when the COVID-19 public health emergency ends, as well as the actions states must take to ensure that eligible individuals retain coverage in Medicaid and CHIP, and that beneficiaries ineligible for Medicaid

or CHIP are able to seamlessly transition to Marketplace coverage or other affordable coverage for which they are eligible.

Medicaid and CHIP enrollment increased significantly between March 2020—the start of the Health and Human Services designated COVID-19 Public Health Emergency (PHE)—and February 2021. As of February 2021, more than 81 million individuals were enrolled in Medicaid and CHIP, an increase of 10.4 million individuals from March 2020, or about 15 percent.

Stay-at-home orders, social distancing mandates, and transitions to telework affected routine state operations such as processing applications, redeterminations, and renewals. In response, Congress passed the Family First Coronavirus Response Act (FFCRA), which provides states a 6.2 percentage point FMAP increase if they implement a number of actions to help provide continuous coverage for individuals during the declared public health emergency. The Continuous Enrollment Provision—one of the main drivers of the increase in enrollment over the past year—was among the actions states were required to implement as a condition of receiving the increased funding. Any state that takes the increased funding must keep those individuals enrolled until the month in which the Public Health Emergency ends.

All states and territories have taken the option but will transition to normal operations when the Public Health Emergency ends. While CMS is providing guidance to states about the return to normal operations, states have significant backlogs of pending renewals, redeterminations, and verifications of information that they must complete. Although the states are expected to take steps to mitigate inappropriate losses in coverage when they resume normal operations, CMS anticipates challenges, particularly around eligibility and enrollment.

Given that many individuals have not received a renewal or redetermination for three years or more in certain circumstances, the risk of inappropriate terminations of eligible individuals and procedural terminations is high. In some instances, beneficiaries may have moved and have not received coverage renewal notices and may lose coverage as a result. Some beneficiaries who received coverage when their income dropped during the Public Health Emergency may be participating in a regular Medicaid renewal process for the first time.

Among the challenges to the states is the timely processing of applications. Early in 2020, when COVID numbers were very high and employers shifted to a telework environment, state offices were unable to keep up with the volume of applications they received. While many states may have addressed the application backlog, CMS is issuing guidance to states to ensure that they process applications in a timely manner. In addition, many states have not completed renewals or redeterminations of eligibility, and must do so for all individuals whose eligibility redetermination has been delayed as a result of the public health emergency. If the states are unable to or can't renew coverage based on available information, individuals and families will receive a form through which they will provide data and documentation. In addition, if states did not require documentation when the beneficiaries were enrolled, the states must take steps to verify the information after the end of the Public Health Emergency.

Among the anticipated challenges to maintaining coverage for eligible individuals are the large volume of redeterminations and other actions that states must process, the length of time since many beneficiaries last had a full eligibility redetermination, and outdated mailing addresses due to movement during the Public Health Emergency. In addition, some individuals may have had an increase in income during the continuous enrollment requirement and may be

deemed ineligible for Medicaid and CHIP during the verification process. While the goal is to ensure that individuals continue to be enrolled in the appropriate program, ensuring the individual does not suffer a gap in coverage during the transition is a challenge.

In addition, CMS is encouraging states to complete regular renewal or redetermination through an administrative or passive renewal process in which the states complete the process without sending forms to the individuals. CMS continues to encourage states to adopt several available streamlined enrollment and retention strategies, such as continuous eligibility for children through which states disregard periodic changes in family circumstances between regular renewal periods. Other options include express-lane eligibility, a process that uses findings from other state benefit programs to enroll and renew coverage.

CMS is considering additional options to facilitate transitions to other health coverage. For example, individuals ineligible for Medicaid and CHIP will receive an account transfer communication from their state. The Federally Facilitated Marketplace sends a notice to the individual, after which the individual completes additional information and enrolls in a plan. CMS is looking at ways to streamline that process and close the gap in coverage.

### **Discussion of Recommendations among APOE Members and Ms. Stephens**

Following the discussion, the panel made a series of preliminary recommendations, including addressing the population of older adults with disabilities who became eligible for Medicare and who cannot get a Medigap policy; improving the re-enrollment and revise notices to make them more understandable; addressing the customers who missed their Medicare initial enrollment period during the Public Health Emergency when they were enrolled in Medicaid as these customers will soon lose their Medicaid coverage; and creating a toolkit that allows consumers to see all the options available to them, where they are in the process, and what they need to do. The panel recommended CMS work with community health centers and faith communities to communicate information that automatic rollovers will soon end; address the disincentive to re-enroll by working with community partners to let consumers know that it is time to renew; conduct outreach to providers who have a financial incentive to ensure consumers have coverage; work with community health workers who are familiar with people in their community and the enrollment processes; work with local public health departments, which have good outreach to consumers; work with schools and cooperative extension services to help disseminate information; and encourage states to work with managed care insurers to provide enrollment information to consumers and resources about enrollment options.

The panel further recommended increased use of electronic communications to address delayed or lost mail and mobile-friendly applications as consumers are more often responding to surveys electronically by phone rather than by email. In addition, the panel recommended CMS partner on outreach with the American Case Management Association and the Case Management Society,, patient advocate organizations, community health organizations, visiting nurse associations, Boys and Girls Clubs, YMCAs, managed care and community organizations such as Meals on Wheels, Federally Qualified Health Centers (FQHC), hospital clinics, pediatricians and family physicians, OB/GYNs, professional associations, the Administration for Community Living, Area Agencies on Aging, and health center Navigators. The panel recommended CMS consider additional outreach around maternal and child health and ways to make enrolling across products seamless for consumers.



**Public Comment**

***Dr. Margot Savoy, APOE Chair***

John Ciliberto, an attorney who has worked with legal aid organizations, said there are opportunities for legal aid organizations to provide specific information on penalties consumers may face because of missed enrollment deadlines. Mr. Ciliberto asked about the resources that are provided to legal aid organizations to educate consumers on Medicare and Medicaid. He discussed ambulance fees as one example, noting that it is one way in which consumers incur unexpected costs.

**Final Comments**

***Dr. Margot Savoy, APOE Chair***

Dr. Savoy thanked the panel members for their participation and valuable feedback, and informed the panel the next meeting will take place virtually on September 15, 2021.

**Adjourn**

***Lisa Carr, DFO, OC, CMS***

Ms. Carr thanked participants and adjourned the meeting at 4:27 p.m.