

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

**The Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
March 22, 2017**

**EXECUTIVE SUMMARY**

**Open Meeting**

*Thomas Dudley, Designated Federal Official, Office of Communications (OC), CMS*

Mr. Thomas Dudley called the meeting to order at 8:38 a.m. He welcomed all participants and served as the Designated Federal Official (DFO) to ensure compliance with the Federal Advisory Committee Act (FACA). Mr. Dudley asked any lobbyists in attendance to please identify themselves as such prior to speaking. He then turned over the meeting to the APOE Chair, Louise Knight.

**Welcome and Introductions**

*Louise Knight, APOE Chair*

*Susie Butler, Director, Partner Relations Group, OC, CMS*

Ms. Knight welcomed all panel members. Panel members then proceeded to introduce themselves and their organizations.

**Recap of September 21, 2016 Meeting**

*Louise Knight, APOE Chair*

*Susie Butler, Director, Partner Relations Group, OC, CMS*

Ms. Knight informed participants that the minutes of the last meeting were available in their packets in addition to the recommendations made by the panel. Ms. Butler said that CMS agreed to implement, or has implemented, 17 of the 20 recommendations addressed. She explained that the three remaining recommendations were not wholly accepted because CMS does not have access to an electronic health records dataset to verify the reliability between Medicare claims data and utilization of preventive services. The other two recommendations pertained primarily to the Centers for Disease Control and Prevention.

**Social Security Number Removal Initiative (SSNRI)**

*Julie Franklin, Director, Integrated Communications Management Staff, OC, CMS*

Ms. Franklin's presentation focused on the Social Security Removal Initiative (SSNRI), which requires the removal of Social Security Numbers (SSNs) from all Medicare cards by April 2019. The gender and signature line will also be removed from the new Medicare cards. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility

status, and claim status. The MBI will provide better protection for information, benefits, and payments. The MBI will be 11 characters in length and made up of only numbers and uppercase letters (no special characters).

Beginning in April 2018, new Medicare cards with the MBI will be sent to every Medicare beneficiary. In all, CMS will have sent approximately 60 million new Medicare cards with the MBI by April 2019. Changing from the SSN to the MBI is a complex logistical endeavor that will require many changes to CMS systems as well as to the systems of other partners.

In terms of education, CMS will involve all stakeholders through existing vehicles for communication, including Open Door Forums, webinars, conferences, and newsletters. With respect to previous efforts, from March to August 2016 listening sessions were conducted with Medicare health plans, providers, billing agents, technology/form designers, and advocacy groups. In September 2016, CMS launched SSNRI webpages on CMS.gov (<http://go.cms.gov/ssnri>) which include key initiative information for specific audiences.

### **Discussion of Recommendations between APOE Members and Julie Franklin** ***APOE Members and Julie Franklin***

Following the previous presentations, the panel provided a series of preliminary recommendations.

The panel suggested developing messaging around the upcoming MBI including a photo of the new ID with the MBI. They suggested that all beneficiary communications reassure that the change is for security purposes to protect beneficiary identity and will have no effect on the level of benefits. Beneficiary communications should be in multiple languages and include as a strategy reaching out to local ethnic media and CBOs to educate the community in hard-to-reach populations.

The outreach strategy should also include a broader range of print media and radio (i.e., beyond digital) and include efforts that have been useful in the past. Campaigns should include messaging to beneficiaries about bringing their card to provider appointments. Panel members also suggested providing a library of resources that can be downloaded from the SSNRI website that includes posters, postcards, flyers, etc. for providers to post/display at the point of service. CMS should also create a portal (or hotline) for providers to look up the new MBI based on a patient's SSN, DOB, name, or HICN.

Panel members suggested notifying EHR vendors and billing systems in advance of the technical/programming modifications and also providing guidance to providers around expectations surrounding maintenance of HICNs on their records. CMS should notify state Medicaid agencies around the new MBI that will affect dual eligible populations. It is important to specifically target FQHCs and the BPHC to engage safety net providers that serve traditionally disadvantaged populations. Organizations like America's Essentials Hospitals could also communicate with safety net providers.

From a data standpoint, the panel suggested communicating with CMS research and evaluation teams and with the ResDAC to ensure development of data continuity plans as primary identifiers change. For consumers, they suggested working with third-party sources of information (such as search engines, fact-checking websites, etc.) to provide information in advance of the card roll out so that the appropriate information will appear on searches.

These preliminary recommendations will be reviewed and revised by the Panel members before the final recommendations are developed.

**CMS Children’s Oral Health Initiative: Improving Outreach, Access, and Outcomes**

*Laurie Norris, JD, Senior Policy Advisor, Division of Quality and Health Outcomes in the Center for Medicaid and CHIP Services, CMS*

Dr. Norris spoke about CMS’s Oral Health Initiative (OHI). She explained that diseases like cavities are inequitably distributed with 80 percent of the disease found in 20 percent of children – mostly Medicaid children.

Between 2011 and 2015, 26 states submitted their State Oral Health Action Plans and 13 states participated in learning collaboratives. The technical assistance tools provided to states included: Keep Kids Smiling compilation of promising approaches; free “Think Teeth” consumer education materials; oral health PIP template and handbooks; and online training modules for reporting 416 dental data.

The CMS Advances Oral Health Initiative 2.0 has as its aim to work with states to increase by 10 percentage points the proportion of children receiving a preventive dental service. At a national level, the baseline in 2011 was 42 percent and the goal is to reach 52 percent by 2018. Progress has been made to date. In 2015, the percentage of children receiving a preventive dental service climbed to 46 percent. In addition to a national initiative, each state has its own baseline and goal.

To improve outreach CMS developed the “Think Teeth” campaign, which includes educational tear pads, flyers, and posters for consumers. Efforts also include Facebook posts, Tweets, blog articles, website buttons and banners, as well as distribution tips. A “Find a Dentist” widget has been created that can be posted on webpages. The widget allows individuals to select their state, a benefit plan, enter their zip code, and find dentists.

Dr. Norris presented some data on dental visits. Between 2000 and 2014, a higher percentage of children in all racial and ethnic groups saw the dentist. Unfortunately, the percentage of children ages 5 and 9 with untreated tooth decay is still significantly different between different races and ethnicities, especially for American Indian and Alaska Native children. Data show that children in lower-income families have significantly more decay than children in high-income families.

Dr. Norris explained that CMS has launched a value-based payment project as a way to begin to address these and other issues. Dental and medical practitioners across the country have developed a different way to manage this disease as a chronic disease in order to help children get healthy and stay healthy.

To support these types of practices, CMS will partner with four states to support innovative practitioners. The goal is to test the project with the ultimate goal of supporting practitioners so they can continue to practice in this manner.

### **Discussion of Recommendations between APOE Members and Dr. Norris** ***APOE Members and Laurie Norris***

Following the previous presentation the panel provided a series of preliminary recommendations. The panel suggested focusing on dental hygiene and dental hygienists as partners as well as partnering with campaigns related to oral cancer. The panel also suggested examining any possible training opportunities for members of the health care team (such as nurses) to apply the fluoride varnish in children.

The panel further suggested presenting and collaborating with AAP, AAFP, and other primary care provider organizations to promote the “Think Teeth” campaign and OHI initiative. These and other partners could also help by posting the CMS dental widget on their websites.

From a partnership standpoint, the panel suggested partnering with SMAs on ED utilization projects related to dental ED visits; identifying and working with SMAs on reimbursement for fluoride varnish and sealants performed by primary care providers; partnering with dental plans (e.g., DELTA) who are moving to value-based contracting with their dental provider networks; and partnering with quality organizations such as HEDIS to include pediatric dental measures. In addition, it would be helpful to partner with Google and search engines to have the dental widget prioritized when a dentist locator tool is searched. The panel also suggested adding a link through the dental widget tool for providers to be able to populate their participation in Medicaid and managed care.

The panel suggested developing “Think Teeth” materials specific to rural and under-dental-resourced areas that help parents navigate or tolerate wait times for appointments. Messaging could be enhanced for special populations including children and youth with special needs with the hopes of creating a “bottom-up” groundswell to target messaging to blogs and other ways they communicate with each other. Existing messaging around “Think Teeth” could be supplemented to include other implications outside of pure drastic medical interventions (e.g., cosmetic interventions) and include “Think Teeth” messaging in day cares, schools, and other relevant venues. Messaging should include coverage to free clinics, mobile clinics, and dental schools that provide services. It would also be helpful to target community health workers and social workers to increase education and awareness for “Think Teeth.”

Other recommendations included linking publicly reportable data shared in the presentation to other data and initiatives from CMS in partnerships with states; mirroring the “CDC 80 percent by 2018 campaign” with an “OHI 52 percent by 2018 campaign”; recording and posting presentations on YouTube, the MLN network, and others; addressing the need for pediatric dental care in urban areas; and following recommendations for marketing and communication (e.g., libraries, buses, etc.).

These preliminary recommendations will be reviewed and revised by the Panel members before the final recommendations are developed.

### **Medicare Shared Savings Program Voluntary Alignment**

***Terri Postma, MD, CHCQM, Performance-Based Payment Policy Group Center for Medicare, CMS***

The Medicare Shared Savings Program (Shared Savings Program) is part of CMS' strategy to promote delivery of health care aimed at reducing fragmentation, improving population health, and lowering overall growth.

Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). ACOs are assigned a beneficiary population to better coordinate care and are assessed annually on 33 quality measures.

The most recent performance results (2015) show continued quality improvement and the fact that more ACOs share savings over time. In terms of quality, ACOs that reported quality in both 2014 and 2015 improved in 84 percent of the quality measures. From a financial standpoint, the ACOs generated program savings of \$429 million.

Voluntary alignment is a process by which a beneficiary can indicate to CMS whom they believe is their "main doctor." The goal of incorporating beneficiary preference into assignment is to help ACOs increase patient engagement, improve care management, achieve better health outcomes, and lower growth costs.

Starting this spring, Medicare fee-for-service beneficiaries will be able to search for and select a "main doctor" through Physician Compare and save the information to their MyMedicare.gov account. The ACO with whom the clinician is associated will become responsible for coordinating the beneficiary's care in the coming performance year.

In terms of outreach, CMS plans to amend the *Medicare & You Handbook* to alert beneficiaries about this MyMedicare.gov feature and inform them how the Shared Savings Program will use this information for purposes of holding ACOs accountable for the beneficiary's overall care. The Shared Savings Program also plans to develop informational materials, including a beneficiary-centered brochure that ACOs and their participating practitioners can use at the site of care.

### **Discussion of Recommendations between APOE Members and Dr. Postma**

***APOE Members and Terri Postma***

Following the previous presentation the panel provided a series of preliminary recommendations. The panel suggested using simple terminology in communications to reduce the need for over explanation of what an ACO is and instead focus on "why" it is necessary/needed. It would also help to develop a concise, concrete statement of benefit for beneficiaries and avoid any language suggesting cost savings or restrictions on provider choice. Communications should use

linguistically appropriate content. Adding videos or other educational materials on the portal to promote benefits of ACO participation (care coordination, medical home, and high quality care) would be helpful. CMS should also consider using Medicare beneficiaries in focus groups for the development of videos and marketing materials.

The panel suggested deploying more MyMedicare.gov navigators (e.g., kiosks in the physician practices perhaps with navigators included) and ensuring that the CMS website has a caregiver component with secure access. Creating a digital app strategy that combines access to MyMedicare.gov, new MBI, health maintenance reporting, and reminders might be helpful for both beneficiaries and providers. It would also help to partner with Google and other search engines to work on search optimization to elevate MyMedicare.gov in the search results. The panel also suggested partnering with Julie Franklin and her project regarding the new Medicare card.

The panel additionally suggested that when a voluntary alignment is made, individuals should be informed that they might get additional information from the ACO with which the physician is aligned. Other suggestions included: incorporating a default voluntary alignment for Medicare beneficiaries who have a PCP assignment from claims to an ACO; labeling voluntary alignment as primary care medical home within the portal; closing the loop of voluntary alignment with provider notification by ACO; linking ACO websites to voluntary and default alignment selection when available; educating SHIP counselors and open enrollment navigation assistants about the new portal; and harmonizing CCM PCP billing with default voluntary alignment in the portal.

These preliminary recommendations will be reviewed and revised by the Panel members before the final recommendations are developed.

### **Public Comment**

*Louise Knight, APOE Chair*

No public comments were offered.

### **Recap of Meeting and Final Comments**

*Roanne Osborne-Gaskin, APOE Co-Chair*

Dr. Osborne-Gaskin thanked everyone for coming. She also thanked all presenters as well as the staff who helped organize the meeting, including Mr. Dudley.

Dr. Osborne-Gaskin provided a recap of the recommendations made during the day. She explained that the preliminary recommendations provided by the APOE would be revised and finalized by the panel members.

She added that she appreciated the depth of experience that panel members brought to the table to make the recommendations possible.

### **Adjourn**

***Thomas Dudley, DFO, OC, CMS***

Mr. Dudley thanked all members and speakers for their participation. He adjourned the meeting at 2:45 p.m.