

**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
Washington, DC 20201
July 16, 2019**

EXECUTIVE SUMMARY

Open Meeting

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

Ms. Carr called the meeting to order at 8:40 am. She welcomed all participants and served as the Designated Federal Official (DFO) to ensure compliance with the Federal Advisory Committee Act (FACA). Ms. Carr asked any lobbyists in attendance to please identify themselves as such prior to speaking. She then turned over the meeting to the APOE Chair, Louise Knight.

Welcome and Introductions

Louise Knight, APOE Chair

Ms. Knight welcomed all panel members. Panel members and speakers then introduced themselves.

Swearing In of New APOE Members

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

Ms. Butler conducted a group swearing in for all new members. Members read in unison the “Oath of Office.” The new panel members sworn in were Ms. Angie Boddie, Ms. Julie Carter, Mr. Scott Ferguson, Ms. Leslie Fried, Mr. David Goldberg, Dr. Jean-Venable “Kelly” Robertson Goode, Ms. Cheri Lattimer, Dr. Michael Minor, Dr. Margot Savoy, Congresswoman Allyson Schwartz, and Ms. Tia Whitaker.

Ms. Butler welcomed all new members to the panel.

Certificates to Departing APOE Members

Louise Knight, APOE Chair

The following members with expiring terms were offered a certificate of appreciation: Mr. Robert Blancato, Dr. Dale Blasier, Ms. Deborah Britt, Mr. Robert Espinoza, Ms. Kamilah Pickett, and Dr. Deena Chisolm. These members will serve until September although this will be their last in-person meeting.

Recap of April 10, 2019 Meeting and CMS Response to APOE

Louise Knight, APOE Chair

Participants were informed that an executive summary of the April 10, 2019 meeting could be found in their packets. They were encouraged to read it at their leisure.

Medicare Advantage Benefit Flexibility

Heather Barkes, JD, Acting Division Director, Center for Medicare Drug and Health Plan Contract Administration Group, Division of Policy, Analysis, and Planning, CMS

Medicare Advantage (MA) Plans are health plan options approved by Medicare and run by private companies. MA plans provide Medicare-covered benefits to beneficiaries and may offer extra benefits that Original Medicare does not cover, such as vision and dental services. These “extra” benefits are called supplemental benefits.

New changes are poised to impact MA plans. In the past, MA plans were required to offer the same benefits and cost sharing to all plan enrollees. However, as of 2019 MA plans may: 1) Reduce cost sharing for certain covered benefits; 2) Offer specific tailored supplemental benefits, and 3) Offer different deductibles for beneficiaries that meet specific medical criteria. Targeted benefits must be offered uniformly to all enrollees with a specified health status or disease state. Also, in order to identify eligible enrollees, the plan must use medical criteria that are objective and measurable.

CMS defines a mandatory or optional “supplemental health care benefit” as an item or service that is not covered by Original Medicare, is primarily health related, and for which the plan must incur a non-zero direct medical cost. In addition, supplemental benefits must be medically appropriate, focus directly on an enrollee’s health care needs, and be recommended by a physician or licensed medical professional as part of a care plan if not directly provided by one.

Supplemental benefits must not include items or services used to induce enrollment or duplicate Medicaid, including the State Medicaid or local benefits for enrollees who are eligible to receive identical Medicaid services. Examples of supplemental benefits include adult day care services, home-based palliative care, in-home support services, transportation for non-emergent medical services, and home/bathroom safety devices and modifications.

The Bipartisan Budget Act of 2018 expanded the types of supplemental benefits that may be offered by MA plans to chronically ill enrollees. These are referred to as Special Supplemental Benefits for the Chronically Ill (SSBCI) and will begin to be offered in 2020. Medicare considers a chronically ill enrollee as an individual who: 1) Has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee; 2) Has a high risk of hospitalization or other adverse health outcomes; and 3) Requires intensive care coordination.

SSBCIs are not required to be primarily health related and may be offered non-uniformly to eligible chronically ill enrollees. However, the item or service needs to have a reasonable expectation of improving or maintaining the health or overall function of the individual enrollee.

Examples of SSBCIs include transportation for non-medical needs, pest control, indoor air quality equipment and services, and access to community or plan-sponsored programs and events to address enrollee social needs. The latter can include non-fitness club memberships, community or social clubs, park passes, access to companion care, marital counseling, family counseling, classes for enrollees with primary caregiving responsibilities for a child, or programs or events to address enrollee isolation and improve emotional and/or cognitive function.

Discussion of Recommendations among APOE Members and Ms. Barkes

Following the presentation, the panel provided a series of preliminary recommendations including developing specific communications and marketing plans for each of these supplemental plans (e.g., Who is eligible? What does it cover? What is available to the beneficiary? How does the beneficiary qualify? How do these compare? Etc.); and using infographics/icons for differentiation among programs.

The panel recommended educating providers about identifying patients who could be helped by the resources offered. Also, physicians, health care providers, SHIP coordinators, health insurance navigators, and certified insurance counselors should be educated and involved as a resource to inform and educate consumers.

It was also recommended that the program address issues surrounding transportation including the types, quantity, and quality of transportation available; partnering with others who may already have transportation in place (e.g., churches); and providing laundry services, plumbing, home cleaning, and transportation to religious services as part of the social needs benefits of SSBCI.

Panelists recommended that materials be translated into various languages and/or have a multilingual call-in number for those who may need to access services but don't speak English; and provide fall prevention, nutritional counseling, health literacy, and incentives for joining evidence-based wellness programs.

Other recommendations included developing metrics to measure success; considering data monitoring, utilization, and quality; monitoring race and ethnicity to maintain equity; and considering oversight of communications materials, especially in areas where there may be various plans.

SUPPORT Act Section 6065 - Questions to Facilitate Stakeholder Consultation Requirements Presentation

Barry Marx, MD, Director of the Office of Clinician Engagement and Medical Officer in the Center for Clinical Standards and Quality, CMS

The Substance Use-Disorder Prevention that Promotes Opioid Recovery & Treatment (SUPPORT) for Patients & Communities Act was signed into law on October 24, 2018. The Act addresses the opioid crisis through various strategies.

One of the sections within the act requires that the Secretary of Health and Human Services (HHS), after consultation with stakeholders, establish thresholds for identifying whether a prescriber in a specialty and geographic area is an outlier prescriber of opioids as compared to other prescribers. The act also requires the Secretary to include information on opioid prescribing guidelines.

By January 1, 2021, all outlier providers prescribing opioids will receive an annual notification with information on how they compare with others in the same specialty and geographic area. The frequency of the notification may change after five years, based on stakeholder input and changes in opioid prescribing trends. In addition, outlier providers will receive information on opioid prescribing guidelines.

Persistent outlier prescribers will be required to enroll in an educational program and will be provided with an opportunity to correct prescribing patterns. The Secretary of HHS will also share information on outlier prescribers with Medicare prescription drug plans and Medicaid Advantage plans.

Dr. Marx asked the Panel to provide recommendations on specifics surrounding the provider reports as well as the thresholds used in the reports.

Discussion of Recommendations among APOE Members and Dr. Marx

Following the presentation, the panel provided a series of preliminary recommendations including providing physicians with a non-judgmental, objective report; presenting the information in the report as “beneficial” vs. “punitive” (e.g., keeping patients safe); being transparent as to why physicians are being studied and what the ramifications will be; being clear on what the provider needs to do (i.e., actionable items); providing physician prescribing information on the existing threshold measures as well as the physician’s deviation from the mean; and explaining why the CMS report is similar/different to other reports the provider may already be receiving.

The panel recommended considering the burden on providers; extracting the information needed from existing datasets or EMRs; involving dentists and pharmacists in the initiative; using CMS subspecialty codes to identify specialties; making the state the smallest geographical area for monitoring; prescribing guidelines that include race, ethnicity, and gender; developing a multimodal opioid strategy; offering the Chronic Disease Self-Management program as a

resource to providers; and informing providers of chronic pain management alternatives they can use with some of their patients.

It was also recommended that CMS develop a list of the top 20 chronic pain conditions treated as well as the number of patients treated by each provider; consider that there are various types of pain such as sports injury, chronic pain, and post-surgical pain; keep in mind that many chronic pain conditions are managed across specialties; and consider hospice and palliative care providers when interpreting data.

Other recommendations included considering issues surrounding scope of practice, state laws, setting, currently available systems, and existing promising pilot programs; working with medical schools or residency programs; instructing patients on how to safely store and destroy medications; and coordinating with existing groups that address opioid issues as well as pain management alternatives.

The Office of Communications and CMS Priorities

Karen Aldana, Deputy Director, OC, CMS

Ms. Aldana provided a brief description of CMS's 16 priorities, which are presented below.

- **Better Care for Dual Eligibles** – improves quality, reduces costs, and improves the customer experience for people eligible for both Medicare and Medicaid.
- **Ensuring Safety and Quality** – with a focus on better patient health outcomes, CMS is holding providers accountable for providing safe and effective care, while minimizing administrative burden to ensure clinicians can spend more time with patients.
- **eMedicare** – provides a seamless online health care customer experience to meet the growing expectations and needs of tech savvy Medicare beneficiaries.
- **Fighting the Opioid Crisis** – decreases the rate of opioid use disorder and reduces deaths by focusing on preventing opioid overuse, increasing access to treatment, and targeting improvements through data analysis.
- **Fostering Innovation** – ensures that beneficiaries have access to the latest medical technologies and removes barriers to advancing innovation across our health care system.
- **Innovative Payment Models** – advances innovative payment structures to move our health care system to one that incentivizes value by rewarding quality and performance, innovation, improved health outcomes, and lower program costs.
- **Lowering Drug Prices** – executes the President's Blueprint to lower prescription drug prices for all Americans through stronger competition, better negotiation, incentives for lower prices, and increased transparency.
- **Marketplace Choice and Affordability** – creates affordable coverage options for every American seeking insurance on the individual health insurance market.
- **Modernizing CMS** – transforms how CMS currently operates to be more efficient and effective in promoting integration and better collaboration among CMS staff, and to support more effective engagement with stakeholders.
- **MyHealth EData** – unleashes data to give patients control of their health care information and allows those data to follow them throughout their health care journey.

- **Patients Over Paperwork** – reduces unnecessary regulatory burden to allow providers to concentrate on their primary mission: improving patient health outcomes.
- **Price Transparency** – empowers patients with the information they need so they can make decisions based on cost and quality, which will make the health care system evolve to one that competes for patients.
- **Protecting Taxpayers Dollars** – enhances and modernizes program integrity to combat waste, fraud, and abuse.
- **Rethinking Rural Health** – ensures that individuals who live in rural America have access to high quality, affordable health care through new and creative ideas such as Telehealth.
- **Strengthening Medicare** – modernizes Medicare to empower beneficiary choices and unleashes private sector innovation to improve care.
- **Transforming Medicaid** – transforms Medicaid by fostering increased state flexibility and innovation, promoting greater accountability for outcomes, and ensuring stronger program integrity for taxpayers.

Ms. Aldana informed the group that CMS will develop a media campaign within the MyHealth EData initiative. The campaign will be called *#ShareYourStory* and be launched in Twitter. The goal is to get individuals to share their stories and experiences.

Discussion of Recommendations among APOE Members and Ms. Aldana

Following the presentation, the panel provided a series of preliminary recommendations including creating a few stories to set the tone, language, and visuals for others to create their stories; asking questions to get the dialogue started (e.g., “What did you think about your plan?”); determining the purpose of the hashtag and the “why” behind the campaign (e.g., engagement, communication, etc.); using the NPR [StoryCorps](#) model as a guide; curating some of the stories to make sure the campaign is on target; and considering the possibility of trolling and how to address it (e.g., a crisis communication plan).

The panel recommended obtaining stories from people who are on the ground; developing beneficiary stories with help from caregivers, providers, social workers, medical school staff, case managers, nurse practitioners, and other professionals; having a chat assistant on the CMS site to let people know that they can tell their story; adding messaging to the letter Social Security sends to beneficiaries about eligibility; collaborating with CMS regional offices; collaborating with the USDA, which has access to rural areas; and inviting social media influencers to be part of the campaign.

It was also recommended that CMS develop consumer testing to help inform the campaign; define metrics to determine if the campaign were successful; collaborate with fraternities and sororities; partner with the Caregiver Action Network and the Family Caregiver Alliance; and develop campaign collateral materials for children and caregivers.

Other recommendations included that the campaign consider monitoring and privacy issues; develop hashtags in different languages to capture wide diversity; and consider some of the ethical consequences of individuals sharing their story.

Listening Session: Prior Authorization

Mary Greene, MD, Senior Advisor, Office of the Administrator, CMS

Marion Couch, MD, Senior Medical Advisor, Office of the Administrator, and Medical Officer, Center for Clinical Standards and Quality, CMS

Dr. Greene said that Patients Over Paperwork – a nearly two-year-old CMS initiative – focuses on reducing the unnecessary regulatory burden. Over time the team has obtained valuable input from external stakeholders including clinicians, beneficiaries, provider organizations, and others. One of the initiative’s goals is to try to understand how CMS rules impact provider day-to-day operations.

Stories from providers – in essence, short clinical vignettes – are obtained from the field and taken back to those developing policy, in order to start thinking about policy more broadly and with additional context.

Input on various topics and areas of interest has been obtained through listening sessions with those in the field. Of these, prior authorization is now emerging as the number one source of burden for clinicians. Over the next few months CMS will meet with many groups, including this panel, to learn about how they understand prior authorization, how it works, and how it impacts their day-to-day operations.

Some of the challenges being faced is that prior authorization does not seem to be carried out efficiently. Also, more transparency is needed with respect to the decision-making process. In other words, one of the goals is to find out ways that CMS can make prior authorization more efficient, more transparent, and more standardized.

Suggestions from the panel included the following: pre-populating paperwork using the patient’s EMR; developing an online checklist; obtaining an immediate response; reducing the response time on the authorization; and submitting information through an online system rather than via fax.

Public Comment

Louise Knight, APOE Chair

No public comments were offered.

Adjourn

Lisa Carr, DFO, OC, CMS

Ms. Carr thanked all members and speakers for their participation. Before adjourning the meeting, she announced that the next meeting is expected to be held on November 14, 2019. This will be an in-person meeting in Washington, DC.