Meeting of the Advisory Panel on Medicare Education (APME)
Centers for Medicare & Medicaid Services (CMS)
October 17, 2006
Marriott at Metro Center
775 12th Street, N.W., Washington, D.C. 20005

Location:
The meeting was held at the Marriott at Metro Center, 775 12th Street, N.W., Washington, D.C. 20005.

Federal Register Announcement:
The meeting was announced in the September 22, 2006 *Federal Register* (Volume 71, Number 184, Pages 55481-55482) (Attachment A).

Panel Members Present:
Anita Boles, Independent Consultant, Health Communications
Gwendolyn T. Bronson, SHINE/SHIP Counselor, Massachusetts SHINE Program
Dr. Yanira Cruz, President and Chief Executive Officer, National Hispanic Council on Aging
Clayton S. Fong, President and Chief Executive Officer, National Asian Pacific Center on Aging
Nan-Kirsten Forte, Executive Vice President, Consumer Services, WebMD
Dr. Jessie C. Gruman, President and Executive Director, Center for the Advancement of Health
Betty L. Kennard, Vice President of Government Programs and Compliance, Health First Health Plans
Dr. David J. Lansky, Director, Health Program, Markle Foundation
Dr. Daniel Lyons, Senior Vice President, Government Programs, Independence Blue Cross, and APME Chair
Dr. Frank B. McArdle, Manager, Hewitt Research Office, Hewitt Associates
Traci L. McClellan, J.D., Executive Director, National Indian Council on Aging
Dr. Keith J. Mueller, Professor and Section Head, Section on Health Services Research and Rural Health Policy, Department of Preventive and Societal Medicine, University of Nebraska Medical Center
Lee Partridge, Senior Health Policy Advisor, National Partnership for Women and Families
Myisha M. Patterson, National Health Coordinator, National Association for the Advancement of Colored People
Rebecca P. Snead, Chief Executive Officer and Executive Vice President, National Alliance of State Pharmacy Associations
William A. Steel, President, The National Grange
Catherine Valenti, Chairperson/Chief Executive Officer, Caring Voices Coalition
Grant M. Wedner, Manager, Business Development Team, Cosmix Corporation

Panel Members Absent:
Susan O. Raetzman, Associate Director, Public Policy Institute, AARP
Marvin Tuttle, Jr., C.A.E., Executive Director and Chief Executive Officer, Financial Planning Association

Designated Federal Official:
Lynne G. Johnson, Office of External Affairs (OEA), Centers for Medicare & Medicaid Services (CMS)

Others:
A sign-in sheet listing other attendees is incorporated as Attachment B.

Open Meeting and Welcome
Lynne G. Johnson, Office of External Affairs, CMS

Ms. Johnson, the Designated Federal Official for the Advisory Panel on Medicare Education (APME), called the meeting to order. She noted several changes to the agenda and then turned the meeting over to the new APME Chairperson, Dr. Daniel Lyons.

Introduction of Members, Swearing in of New Members
Kathleen Harrington, Director, Office of External Affairs, CMS

Dr. Lyons began by introducing Ms. Kathleen Harrington, who asked panel members to introduce themselves. Each of the panelists identified themselves, the organizations with which they are affiliated, and provided a brief synopsis of their relevant experience. Following the introductions, Ms. Harrington asked new members to stand and be sworn in.

Charge to the Panel and Listening Session with CMS Leadership
Ms. Leslie V. Norwalk, Esq. Acting Administrator, CMS

Ms. Norwalk welcomed the new members and praised the panel for its diversity and efforts on behalf of Medicare beneficiaries, specifically with regard to making sure that people with Medicare understand their benefits and can access them in the way that is most appropriate. She stressed importance of partnerships in making the Part D campaign a success. Through partnerships, we can reach significantly more people than reached before. This is one of the major goals of the panel.

She stated that there is a focus on reaching people where they live, work, play, and pray. We want to reach people not just around the drug benefit, but around Medicare as a whole, moving from being looked at as a bill payer to teaching them about the personal responsibility of their health care.

She noted that the panel was under good leadership with Dan Lyons as chair. She thanked him for his willingness to serve. She asked to hear the member's comments on issues that were important to them and how they can help CMS continue to its partnership focus.

Discussion

Member Comment - Ms. McClellan commented that the various open-door forums have been an excellent resource for tribal providers and IHS-run facilities. She asked about CMS' plans for

getting more general information about Medicare to beneficiaries and noted the general lack of knowledge and understanding of Medicare programs in tribal communities.

Member Comment - Dr. Lansky recommended that CMS pursue a beneficiary-centered view of measurement and reporting and also stressed the importance of long-term strategic thinking to prevent the unnecessary proliferation of measures.

CMS Response - Ms. Norwalk responded that Dr. Lansky's recommendations mirrored the vision of the Secretary and the White House concerning transparency issues and the desire to have meaningful measurements. My Health. My Medicare., CMS' beneficiary-focused tool, will address this issue.

Member Comment - Mr. Fong commented on the need to reach out to low-income seniors and those with the greatest barriers such as the 10 percent not covered by Part D. Many of them are Low Income Subsidy (LIS) beneficiaries who could benefit the most from drug coverage.

CMS Response - Ms. Norwalk noted that under LIS, changes in circumstance can make individuals immediately eligible, and that dual eligibles might not qualify during one month but might qualify the next.

Member Comment - Mr. McArdle suggested that CMS standardize reporting mechanisms and systems to increase efficiency.

CMS Response - Ms. Norwalk explained the challenges of updating and integrating CMS' systems and indicated that much of the agency's efforts in this area are resource-driven. She indicated that it would be very helpful to have feedback on areas in which CMS could make improvements.

Member Comment – Ms Partridge spoke highly about the Nursing Home Compare tool for the help it provides individuals and families making decisions about nursing care.

Member Comment - Ms. Patterson noted that part of NAACP's success in getting out the Part D message was its use of non-traditional means of communication. Many racial and ethnic minority beneficiaries do not have access to the internet or stable addresses at which they can receive mail.

Member Comment - Dr. Cruz reported that lay educators were very important in her organization's efforts.

APME Previous Year Highlights
Dr. Daniel Lyons, APME Chair

Dr. Lyons reviewed the panel's work over the preceding year that included subcommittee activities and work with CMS senior staff on topics such as efforts to educate beneficiaries about prevention and preventive benefits, community-based outreach, and culturally appropriate materials. The committee provided input on CMS publications and websites and also addressed

quality measures. Dr. Lyons noted that information about APME and detailed meeting minutes from previous meetings could be found on the APME website. Minutes from the previous meeting are included in the meeting binder (Attachment C).

Break

The Medicare Drug Benefit 2007 Overview
Ms. Abby L. Block, Director, Center for Beneficiary Choices, CMS (Attachment D)

Ms. Block stated that bringing consumer information and beneficiary-oriented information to Medicare is a high priority. Beginning November 15, the Plan Finder tool will provide the beginning stages of plan performance information such as call center wait times and complaint rates. CMS is looking at a more consolidated and concise way to bring information concerning quality and performance to beneficiaries to help them with decision making.

Ms. Block provided the following highlights on the outlook for Part D year two: covered plan options; premiums; gap coverage; formularies; Medicare Advantage (MA) drug plans; premium data; MA contract and applications data; low-income subsidy issues; and important dates concerning reassignment.

She stated that the outlook for 2007 is positive. More plans will offer coverage in the coverage gap. There will be lower cost options for most beneficiaries and enhanced plan options will be available to enable beneficiaries to obtain more stable monthly costs throughout the year. Ms. Block noted that 83 percent of beneficiaries nationwide will have access to plans with lower premiums than they are currently paying, and all beneficiaries will have access to plans with premiums less than $20. CMS has performed a rigorous formulary review to ensure appropriate access to drugs and avoid potential discrimination against beneficiaries with certain conditions. In addition, she stated that beneficiaries will have greater access to MA plans at a lower cost. There are more MA and Special Needs plans in 2007 than in 2006.

Ms. Block stressed the importance of encouraging individuals who no longer automatically qualify for the Low Income Subsidy (LIS) to apply for the extra help. CMS continues to work with its partners to reach out to this population on an individual basis to remind them to apply. She also addressed reassignments that may affect LIS beneficiaries.

Discussion

Member Comment - Mr. McArdle asked if beneficiaries could decline reassignment.

CMS Response – Ms. Block explained that all randomly reassigned beneficiaries can decline reassignment and opt for any plan they choose. Dual eligibles can change plans each month.

Member Comment - Mr. Fong stated that CMS should make a strong effort to reach the LIS population, especially since it probably includes a large population of minorities, many of whom have language barriers.

CMS Response - Mr. Kickham responded that CMS emphasized the importance of targeting beneficiaries at the ZIP code level in 2006 and that it is working with its partners to pinpoint outreach efforts for 2007.

Member Comment - Ms. Patterson suggested that the panel have access to detailed local data, broken down by race and ethnicity, to help partners target and measure their outreach efforts.

Member Comment - Ms. Partridge asked if it was possible for CMS to communicate the importance of enrolling or changing enrollment early.

CMS Response - Ms. Block stated that CMS is strongly encouraging that all enrollments or enrollment changes be made by December 8 to prevent pharmacy problems in January. Additionally, CMS will be working with the states to prevent last-minute enrollments.

Member Comment – Ms. Patterson inquired whether CMS had figures on the number of beneficiaries who are no longer dually eligible.

CMS Response - Ms. Block stated that 600,000 beneficiaries were no longer dually eligible at the beginning of the year but that number decreased as more people became eligible for Medicaid.

Member Comment - Dr. Lansky asked Ms. Block to discuss what CMS knows about the criteria that people are using for decision making, given the available information, and whether CMS has a set of criteria to define good quality decision making.

CMS Response - Ms. Block explained that data for 2006 show that beneficiaries overwhelmingly chose plans with no deductible, with coverage in the gap, with broad formularies, and with less management. CMS is actively working to determine the information that beneficiaries need and use to make decisions on their plans.

Member Comment - Ms. Snead complemented CMS for leading the efforts and dialogue between the plans and the pharmacy industry that has resulted in great strides in cooperation with regard to exceptions, appeals, formulary management, and the standardization of processes.

Regional Office Medicare Part D Outreach and Education Activities
Ms. Nancy B. O'Connor, Regional Administrator, Region III (Philadelphia), CMS
(Attachment E)

Ms. O'Connor provided an overview of the Regional Offices' (ROs) role in outreach and education concerning Part D. She discussed the frameworks and approaches put in place during the 2006 campaign that will form the basis for the 2007 campaign. She described the structure of the management teams responsible for leveraging existing relationships and building new partnerships in each RO.

Ms. O'Connor stated that CMS defined partnerships based on the partners' reliability to deliver a service in one the following three areas: building awareness in the community; educating

beneficiaries; and counseling and enrollment services. She described CMS' expectations for partners in each of the three groups. Experience has proven that organizations with similar purposes and missions as CMS became the best partners. She also described the overall distribution of partners nationwide and the distribution of partners by type. Ms. O'Connor listed 18 groups for which the ROs identified specific needs and created campaigns that provided tailored messages for these groups.

Ms. O'Connor addressed the upcoming enrollment campaign. Each RO conducted a gap analysis of the 2006 campaign to identify areas that require additional outreach. CMS will target geographic areas with high Medicare populations but low enrollment rates; dual eligible populations; beneficiaries facing significant (10 percent or more) premium increases; and ethnic populations. CMS will also work to establish a self-sustaining network of partners consisting of a core group of partners that can provide resources to educate and enroll beneficiaries.

Messages for the fall enrollment period will encourage beneficiaries to examine their current plans and consider drug plan changes (in the areas of cost, coverage, and customer service), to ensure that their plans cover the drugs they need and that they receive good customer service from their plans. CMS will encourage early enrollment to ensure coverage on January 1, 2007.

Discussion

Member Comment - Ms. Kennard asked if organizations could contact the ROs to identify the CMS campaign contacts in their areas.

CMS Response - Ms. O'Connor replied that they should contact the Regional Administrator or ask for the Part D Campaign Manager.

Member Comment - Ms. Kennard noted that there is confusion among beneficiaries concerning the coverage gap and the lock-in period for non dual-eligibles. She asked how CMS provides beneficiaries with education on those issues.

CMS Response - CMS communicates the fact that dual eligibles can switch plans at any time and also communicates the lock-in period to beneficiaries with managed care drug plans. CMS is emphasizing education concerning the appeals and grievance process for those who are dissatisfied with their plan.

Member Comment - Mr. Mueller noted that enrollment centers were noticeably absent in rural areas and asked if the regional offices had done any analysis of the relationship between enrollment levels and the location of enrollment centers.

CMS Response - Ms. O'Connor stated that the regional offices, including those with large rural areas, have the relationship between enrollment levels and the location of enrollment centers and are trying to build partnerships in areas where gaps exist. CMS is working to use the media in reaching beneficiaries in hard to reach areas. In addition, the SHIPs are working to reach beneficiaries in rural areas.

Member Comment - Mr. Fong asked if there would be funding and resources available for partnerships. He also inquired whether CMS had plans to make the LIS outreach a year-round effort. He also encouraged CMS to focus on educating beneficiaries about coverage in the gap and to promote the use of the Plan Finder.

CMS Response - Ms. O'Connor stated that many of the organizations that participated last year will continue to work with CMS this year.

Lunch Break

Prevention/Quality
Mr. Herb Kuhn, Acting Deputy Administrator, CMS and Director, Center for Medicare Management, CMS

Mr. Kuhn stated that the new strategic plan will help to define the course for modernizing the Medicare program. Goals of the plan include ensuring that Medicare offers up-to-date benefits, health care programs are sustainable for future generations, and that Medicare pays for the kinds of services it wants.

Currently, under fee-for-service plans, 95 percent of Medicare payments go to beneficiaries after the onset of a condition, meaning only five percent goes to prevention. The agency is working on creating a program that encourages, supports, and rewards effective, efficient, and high quality care. Currently, on the fee-for-service side, Medicare pays for resource use, not outcomes, resulting in episodic care and rewards for poor performance. Restructuring the way Medicare pays can increase quality, improve outcomes, and reduce costs. Mr. Kuhn stated that CMS continues to move forward through the following avenues to help beneficiaries and their providers understand that there is information available that will help them make decisions concerning their healthcare: pilot programs, collaborative efforts with stakeholders, provider and clinician-led efforts to develop quality measures, websites, and the My Health. My Medicare. campaign.

Discussion

Member Comment - Dr. Lansky asked how CMS plans to migrate both the payment and measurement systems from the current fee-for-service models that focus on episodic care and processes to those that focus on longitudinal care.

CMS Response - Mr. Kuhn responded that the Provider Group Practice (PGP) demonstration, which works with 10 of the largest group practices in the country, as an example of CMS' efforts to look at the total cost of care and test rewarding providers for providing care that prevents hospitalizations. Initial results from the PGP's first year are promising. CMS is also considering issues such as attribution (in the case of multiple physicians treating a single patient), non-compliant patients, and group models as it tests hypotheses to help it transition to the new model.

Member Comment - Ms. Partridge asked if CMS might undertake a demonstration that would allow savings to Medicare to accrue to Medicaid.

CMS Response - Mr. Kuhn responded that with the exception of the dual eligibles, there is currently no intersection between the two programs. There are opportunities for new thinking and approaches.

Member Comment - Ms. Forte asked if the concepts of consumer directed health care will make their way into Medicare, especially in terms of prevention. Ms. Forte also asked if CMS is looking at patient satisfaction.

CMS Response - Mr. Kuhn responded that it could, especially in areas such as ambulatory care settings. As more information on cost and quality of care in different settings becomes available, patients will begin to make decisions about where they receive care, as it will have an affect on their co-payment for services. In addition, as additional data become available for physicians and hospitals, patients will be able to make decisions based on quality and patient satisfaction. Mr. Kuhn indicated that the Center for Beneficiary Choices has the lead on issue and suggested that it might be a topic for a future APME meeting.

Member Comment - Mr. Fong asked if CMS has considered using communication (language) as a quality measure since it is connected to patient compliance. He also inquired if any of the demonstrations were looking at racial and ethnic groups and disparities.

CMS Response – Mr. Kuhn explained that concerning communication, CMS is looking at ways to reward physicians and other clinicians for time spent discussing treatment regimes with patients. He stated that CMS does have some demonstrations that address disparities.

CMS Response - Ms. Harrington added that CMS would likely form a minority quality council because many of the agency's minority health leadership partners have pointed out that there are minority-specific response differences to certain treatments.

Member Comment - Mr. Mueller suggested that it is important to look at the providers, not just the institution with regard to quality, and cited an example of a hospital that does a low volume of a specific procedure but brings in very experienced surgical teams that do high volumes of that procedure. He also suggested that it would be very helpful if beneficiaries were educated about judging hospitals and facilities based on what they do, e.g., heart surgery, instead a broader set of criteria (everything else).

CMS Response - Mr. Kuhn indicated that CMS will address these issues as it moves forward with quality measures.

Member Comment - Ms. Valenti noted that patients in rural areas often do not have a choice with regard to facilities and that it is important to focus on improving quality across the board. She also suggested that there are lots of little changes that can reduce costs and improve the quality of patients' lives, such as in home infusions by a visiting nurse for non-homebound patients.

CMS Response - Mr. Kuhn cited Medicaid as leading the field in this area and suggested that Medicare might learn from the Medicaid experience with similar initiatives.

Member Comment - Mr. Wedner inquired if CMS has considered reimbursing for technology and for Internet consultations given the increasing use of technology and the Internet by both beneficiaries and providers.

CMS Response - Mr. Kuhn what CMS really wants is to pay for outcomes, and then technology being the enabler to assist the outcomes in the future.

Medicare Tools
Ms. Mary Agnes Laureno, Director, Office of Beneficiary Information Services, CMS
(Attachment F)

Ms. Laureno gave a brief overview of MyMedicare.gov, an online tool that beneficiaries can use to manage their health care, including information on the date of their last preventive service and the due date for the next preventive service. She gave an overview of the following:

- The Formulary Finder tool - generally used by those working with large groups of beneficiaries.
- The Plans in Your State tool - allows users to identify and receive a summary of the types of prescription drug plans, Medicare health plans, and Medicare Special Needs plans in the selected areas.
- The Medicare Prescription Drug Plan Finder is usually used by counselors and individual beneficiaries to find plans that best suits their individual need.
- The Medicare Options Compare tool - allows users to compare original Medicare, Medicare Advantage plans, and Medigap policies.

Ms. Laureno indicated that CMS is open to feedback and will continue to improve the tools and make them easier to use.

Discussion

Member Comment - Ms. Valenti reported that her organization's Director of Education demonstrated the Medicare Options Compare at a conference and that it received high marks from attendees.

Member Comment - Mr. Mueller asked where to find information about the provider networks that the plans use.

CMS Response - Ms. Laureno responded that the Medicare Options Compare tool will tell users how many providers are in the network.

Member Comment - Ms. Snead shared her concerns related to potential cases where switching to lower cost drugs may increase overall healthcare costs and expressed a desire for a qualifier that explains to beneficiaries that one drug change could necessitate changes in other drugs.

CMS Response - Ms. Laureno replied that there are only 56 drugs in the lower cost alternatives. CMS tried to offer these options only for classes of drugs for which there is a consensus about

movement within a therapeutic class and qualified the information with a reminder to consult a physician before making changes.

Member Comment - Ms. Kennard asked if users could use their ZIP code as search criteria and if users needed to input their Medicare number to use the Medicare Prescription Drug Plan Finder.

CMS Response - Ms. Laureno explained that ZIP codes can be used on the Medicare Options Compare tool and that it is not necessary to use a Medicare number to do a general search on the prescription drug tool.

Member Comment - Ms. Boles asked Ms. Laureno about the mechanisms used to collect feedback on the tools in the past and the future.

CMS Response - Ms. Laureno indicated that CMS collects feedback through a number of ways including evaluations by the Center for Beneficiary Choices, usability studies conducted by CMS' web contractor, phone calls, e-mails and from feedback button located on the website.

Member Comment - Dr. Lyons suggested that it would be useful to collect data pertaining to the average time online for Plan Finder users.

Member Comment – Ms. Forte suggested that CMS should consider providing links to information on specific diseases such as diabetes.

SHIPs
Ms. Gwendolyn Bronson, SHINE/SHIP Counselor, Massachusetts SHINE Program, APME

Ms. Bronson told panelists that State Health Insurance Counseling and Assistance Programs (SHIPs) are made up of volunteers who have completed a rigorous training course, are certified by their respective states, and receive ongoing training. The volunteers serve as counselors to Medicare and Medicaid beneficiaries. They explain benefits, help fill out forms, assist beneficiaries with Medicare tools, and provide referrals to other agencies. She noted that her SHIP is anticipating that beneficiaries who did not change plans for 2007 will find that they have different premiums or pharmacy copays and will need assistance in early 2007 to understand the changes to their plans.

The Massachusetts SHIP is working to recruit volunteers with language skills that represent the minority populations in the area and to find new venues for outreach such as shopping malls, senior housing complexes, state fairs, and senior days.

Ms. Bronson concluded by stressing the importance of ongoing training for volunteers and the availability of funds for training.

Public Comment

No requests for public comment had been received prior to the meeting and none were volunteered at this time.

My Health. My Medicare. Overview
Ms. Kathleen Harrington, Director, Office of External Affairs, CMS

Ms. Harrington stressed the importance of building on the lessons learned and the foundation developed during the Part D campaign as the agency moves forward. All of the CMS' activities are focused on the beneficiary and the partners that touch the beneficiary.

CMS wants beneficiaries to see it as a partner in helping them stay healthy and make wise decisions about health care, not just as an insurance company. Two important aspects of this are helping beneficiaries make the most of their benefits, especially the preventive benefits, and helping beneficiaries make the most of the information available to them as they make decisions concerning their healthcare. This is a part of the overall Medicare rebranding strategy.

She stressed the difficulty of reaching the LIS population, including those who will not be redeemed by their states or who will be automatically reassigned, as some of the challenges the agency faces. CMS will use earned media and partnership activities to encourage beneficiaries to decide if they want or need to change plans.

She then went on to ask the panel whether they would approach a prevention campaign from the benefits or from the perspective of specific diseases.

Member Comment - Dr. Lyons suggested that the discussion be framed in terms of primary, secondary, or tertiary prevention, with an emphasis by CMS on secondary and tertiary prevention. He also suggested that CMS encourage pay for performance for improving quality of health care.

Member Comment - Ms. Forte suggested finding a new name for prevention such as wellness or well-being while addressing beneficiaries' pocketbook issues, continuing public/private partnerships (especially with regard to well-being), and dealing with access and distribution issues.

Next Steps
Dr. Daniel Lyons, APME Chair

Dr. Lyons announced that the next APME meeting will be held on January 24, 2007. He reviewed the following items that could be used as the basis for the next meeting's agenda:

- HCAHPS;
- Quality of provider instruments that give additional consumer information;
- Reassignment of dual eligibles, addressing unenrolled and LIS beneficiaries;
- Lessons learned from the grassroots outreach campaign;

- Detailed web site traffic data that relates to the utilization of the new tools; and
- Utilization of the panel to improve the prevention mission.

Adjournment
Dr. Lyons adjourned the meeting at 3:15 p.m.

Prepared by:
Teresa Lucas, Summary Writer and Lynne G. Johnson, Designated Federal Official, Advisory Panel on Medicare Education, Division of Forum and Conference Development, Partner Relations Group, Office of External Affairs, Centers for Medicare & Medicaid Services

Approved by:
Dr. Daniel Lyons, Chairperson, Advisory Panel on Medicare Education

Attachments

A. *Federal Register*, September 22, 2006 (Volume 71, Number 184, Pages 55481-55482)
B. Sign-in Sheet
C. October 17, 2006 APME Meeting Minutes
D. *The Medicare Drug Benefit 2007 Overview,* CMS
E. *Regional Office Medicare Part D Outreach and Education Activities,* CMS
F. *Medicare Tools,* CMS