

Meeting Summary
Advisory Panel on Medicare Education (APME)
Wednesday, February 13, 2002, 9:00 a.m. - 5:00 p.m.

Medicare Education Update
APME Annual Report

Location:

The meeting was held at the Wyndham Washington D.C. Hotel, 1400 M Street, NW, Washington, D.C., 20005.

Federal Register Announcement:

The meeting was announced in the Federal Register on January 25, 2002 (Volume 67, Number 17, Pages 3720-3721) (**Attachment A**).

PRESENT:

Carol Cronin, Chairperson
Diane Archer, President, Medicare Rights Center
Bruce Bradley, Director, Managed Care Plans, General Motors Corporation
Jennie Chin Hansen, Executive Director, On Lok Senior Health Services
Joyce Dubow, Senior Policy Advisor, Public Policy Institute, AARP
Bonita Kallestad, Advocate, Mid Minnesota Legal Assistance
Brian Lindberg, Executive Director, Consumer Coalition for Quality Health Care
Heidi Margulis, Vice President, Government Affairs, Humana, Inc.
Dr. Patricia Neuman, Vice President and Director, Medicare Policy Project, Kaiser Family Foundation
Samuel Simmons, President and Chief Executive Officer, National Caucus and Center on Black Aged
Myrl Weinberg, Executive Director, National Health Council

Staff:

Nancy Caliman, Center for Beneficiary Choices, Centers for Medicare & Medicaid Services

Guests:

Candace Schaller, Vice President, Regulatory Affairs, American Association of Health Plans

Others:

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

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PANEL MEMBERS ABSENT:

Dave Baldrige, Executive Director, National Indian Council on Aging
Dr. Elmer Huerta, Director, Cancer Risk and Assessment Center, Washington Hospital Center
Steven Larsen, Maryland Insurance Commissioner, Maryland Insurance Administration
Dr. Elena Rios, President, National Hispanic Medical Association
Ed Zesk, Executive Director, Aging 2000

Welcome and Open Meeting

Nancy Caliman, Centers for Medicare & Medicaid Services

Nancy Caliman, Designated Federal Official for the Advisory Panel on Medicare Education (APME), called meeting to order at 9:10 a.m.

Review of Agenda/Recap of Previous Meeting/APME Annual Report

Carol Cronin, Chair, APME

The Chair, Carol Cronin, reviewed the agenda for the meeting and gave a brief summary of the previous meeting held on October 25, 2001 (**Attachment C**). During that meeting, Michael McMullan described the fall Medicare ad campaign and members viewed a video of the ads. The Panel then discussed its annual report to the Department of Health and Human Services (DHHS) and the Centers for Medicare & Medicaid Services (CMS) (**Attachment D**). Ms. Cronin commended Ed Zesk, who had served as the chair of the annual report subcommittee, for drafting the report. She commended the members for reviewing the draft, commenting promptly, and being willing to compromise on the content. She said that the annual report was a public document, as of this meeting, and that she would transmit it to the Secretary and Administrator with a cover letter.

Ms. Cronin acknowledged that the meeting was the last for several members. She thanked those members for their contributions, stating that it had been a positive experience. She complimented Ms. Caliman for her work with the Panel. The members introduced themselves expressing their gratitude to Ms. Cronin, Ms. McMullan, and Ms. Caliman for their support of the Panel's work.

Update on Fall Medicare Ad Campaign

Michael McMullan, Acting Director, Center for Beneficiary Choices, CMS

Objective: Ms. McMullan stated that the objective of the fall Medicare ad campaign was to give people with Medicare and their caregivers an awareness of the need to ask questions about their Medicare coverage and to inform them of where they could receive answers to their questions. In that vein, the campaign theme was "Helping you help yourself". Research had shown CMS that older adults want to feel independent and respected. Whether or not they are making their health coverage decisions, they want to be the ones who are addressed in any outreach efforts.

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Assessment: The assessment was conducted by telephone surveys of certain population segments - those 64 and older, African American seniors, Latino seniors, Latino caregivers, and the general caregiver population. The assessment was conducted at three points: before the ads began, at midpoint in the campaign, and following the campaign. Research showed that the campaign achieved the awareness CMS intended. However, people viewing the ad did not retain knowledge of the 1-800 number. The increased volume over the 1-800-MEDICARE helpline decreased after the campaign ended. The audience retained that the ads were about Medicare, not that they were about the Medicare helpline. CMS learned that it needs to employ a more persistent approach. Other findings include:

- The response to the general market ad - the Leslie Nielsen ad - was neutral. It was most popular among younger audiences and men.
- The Hispanic/Latino audience liked the Spanish-language ads but it did not result in retained knowledge of the number. These ads were also more effective in reaching Latino caregivers than reaching Latino beneficiaries.
- The ads worked more effectively with middle- and upper middle-income White audiences and less effectively with minority and low-income audiences.
- There was more awareness of the ads from caregivers in the 18- to 63-year old age brackets than expected.
- The public did not notice the print ads unless they were already looking for the information.

Impact on 1-800-MEDICARE and medicare.gov: CMS increased the capacity of the 1-800-MEDICARE call centers and enhanced the training of their Customer Service Representatives (CSRs) to handle the anticipated call volume. During October, the peak month, calls increased by 75 percent over the previous October. On the heaviest call volume day, there were 56,000 calls compared to 18,000 to 22,000 calls on a typical weekday. The average length of calls increased from 5 to 7 minutes. CSRs answered more questions and made fewer referrals than previously. Ms. McMullan stated that traffic on the medicare.gov site increased. There were 5.9 million page views on the site during October 2001 as compared to 3.1 million in 2000. There were 39.7 million page views on medicare.gov during 2001 as compared to 21.9 million in 2000.

Single 800 Number Pilot: CMS is conducting a pilot project in Pennsylvania to test the use of a single toll-free number for all Medicare contractors who answer customer inquiries. CMS will use this pilot to understand how to manage the call traffic. The objective of the pilot is to understand how to successfully move to a single nationwide number and a system that automatically routes callers to the appropriate contractor.

Medicare & You 2003 Handbook: CMS is revising the *Medicare & You* handbook for 2003 and is eliminating most of the regional and state numbers and referring people to 1-800-MEDICARE. People get confused with the multitude of numbers, numbers may change, and eliminating them would save more than 20 pages of printing and postage. Those who want to comment on the handbook should do so by April.

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Coverage Questions: Ms. McMullan explained that CSRs can tell callers whether Medicare covers categories of services, for example flu shots, but they refer patient-specific questions to carriers and intermediaries.

Promoting 1-800-MEDICARE: A member suggested that CMS promote the 1-800-MEDICARE number on Medicare cards, on the front of the handbook, and by including a tear-off bookmark, magnet, or pencil in the handbook.

Fall 2002 Ad Campaign: The approach for the fall 2002 ad campaign will focus on getting people to remember the 800 number and reinforce the theme of “helping you help yourself”. The goal is to cause people to remember 1-800- MEDICARE in the same way they remember "911." The medium will be television, radio, and some print. Radio is an effective device for reaching minority populations. CMS will run ads throughout the year and more frequently during the open enrollment period. CMS would also like to draw on other campaigns to promote the helpline.

Update on the State Health Insurance Assistance Program
Mike Adelberg, Associate Regional Administrator, Division of Beneficiaries, Health Plans and Providers, Chicago Regional Office, CMS
L. Sue Andersen, SHIP Resource Center
Robert Adams, Acting Director, Division of Community Based Education and Assistance, CMS

Mr. Adelberg, Ms. Andersen, and Mr. Adams covered the following topics pertaining to the State Health Insurance Assistance Program (SHIP) (**Attachment E**): legal mandate, core services, state network, funding, role within the Regional Education About Choice in Health (REACH) campaign, outreach to vulnerable populations, workload, national standards, and CMS's provision of timely information to SHIPs.

Legal mandate: According to Section 4360 of the Omnibus Budget Reconciliation Act of 1990, the Secretary of DHHS must issue "grants to states for the purpose of providing information, counseling, and assistance for the procurement of adequate and affordable health insurance" to Medicare eligible individuals.

Core services: The SHIP provides specialized assistance that other information channels do not provide. The national ad campaign reaches a broad population but does not give detailed information. The web-site and print materials offer information to those who can access information on their own. The 800 number provides one-to-one assistance. The SHIPs provide specialized counseling and assistance for those who need it. SHIPs also advocate for beneficiaries within the system. The counseling covers a broad range of topics including Medicare, Medigap, long-term care, claims assistance, and appeals. SHIPs also provide referrals to other services such as energy assistance.

The SHIP network: The SHIP network includes 53 state-level grantees and over 1,000 sponsoring organizations, 50 percent of which are Area Agencies on Aging. Other sponsoring organizations include community nonprofit, faith-based and fraternal

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organizations, and community hospitals. SHIPs provide health insurance assistance to approximately 2.7 million people a year. They also reach 1.2 million through 30 thousand local educational events.

Funding: SHIP grants totaled approximately \$10 million per year until the passage of the Balanced Budget Act (BBA) and the creation of the Medicare + Choice (M + C) program. With the infusion of M + C user fees, the annual grants increased to \$15 to 19 million between 1998 and 2001. Congress authorized a \$12.5 million budget line for the SHIPs in the 2002 budget. The President's 2003 budget proposes \$12.5 million for the SHIP. Approximately one-half of SHIPs receive additional state support. In some cases, state funding exceeds federal support. Other states provide in-kind support such as office space and liability insurance. Because many SHIPs receive funding from other federal, state, municipal, and private philanthropic sources, in very few cases is the SHIP grant the major source of funding for the SHIP.

SHIP and REACH: The SHIPs are important partners with CMS Regional Offices in conducting the Regional Education About Choices in Health (REACH) campaign. REACH is CMS's locally oriented Medicare outreach and partnership program. The SHIPs cosponsor activities, contribute to REACH business plans, and respond to beneficiaries with crisis situations. For example, SHIPs helped those affected by the Pacificare nonrenewal in Texas and provided bilingual counselors to help those affected by health clinic closures in Florida.

Outreach to vulnerable populations: SHIPs often serve vulnerable populations, including those who have severe disabilities that are a barrier to their understanding and use of Medicare information. The services that SHIPs provide reflect the diversity of the Medicare population in each state. Areas of specialization include working with dually eligible populations and providing long-term care insurance counseling. The SHIPs recruit, or do outreach among, vulnerable populations to ensure that they will be served effectively at the local level.

Workload: The SHIP workload is often unpredictable. Local changes in the health care delivery system affect the amount of outreach they perform. Supplemental grants helped SHIPs handle the increased call volume caused by the fall ad campaign. While some states reported a large increase in referrals during the fall, there were not as many referrals as expected. SHIPs have become accustomed to responding to nonrenewals and most reported that they were able to handle the increase in demand. In terms of volunteer training, CMS has produced a national training manual for the SHIPs and, in the future, will provide web-based training for information intermediaries.

Minimum national standards: The SHIPs adopted minimum national performance standards at their last national conference. The goals of the standards are to promote consistent service from state to state and develop a mechanism for accountability to CMS. The standards exist in six areas: (1) access to service, (2) outreach and education, (3) partnership development, (4) reporting, (5) staffing, and (6) counselor training/quality

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assurance. In 2002, SHIPs will self-assess their performance to identify strengths and weaknesses, and to ascertain whether the standards are realistic for all programs.

Timely provision of information: To provide program updates and other information to the SHIPs, CMS does the following:

- Manages a listserv for the 53 state SHIP directors or their designees.
- Hosts a website, launched in October 2001, www.shiptalk.org, that provides SHIP staff and volunteers with updated information, best practices, and ideas. The site is password-protected allowing discussion and the posting of information beyond Medicare and Medicaid updates.
- Through the SHIP Resource Center, produces a weekly email digest with timely updates on policy. It is accessible by all local SHIP contractors.
- Conducts teleconferences for the SHIPs on emerging topics such as Special Election Periods.

Some members advised that the local SHIPs should be included on SHIP listserv so that they can receive updated information simultaneously with the states. Alternatively, CMS could provide regular program updates by email to any groups who want the information. One member said that CMS should ask the states to give CMS a list of all the local SHIP contractors so that CMS can ensure that the local grantees get the important information they need, notwithstanding the SHIP Resource Center email digest.

SHIP Resource Center: In response to a question, Mr. Adelberg stated that the Resource Center is operated under a one-year, renewable contract between CMS and a private consulting firm. Within CMS, Robert Adams is the key person concerning the SHIP.

Families USA Project: The organization, Families USA, has obtained a 3-year grant from the Robert Wood Johnson Foundation to develop a resource center for health care assistance programs. Kevin Simpson, who was in the audience, is the director of the resource center.

[Whereupon the meeting adjourned for a break and reconvened.]

**CMS Update and Issues
Michael McMullan, CMS**

Medicare & You Handbook: Ms. McMullan said she would welcome comments, by April, on the draft of the *Medicare & You* 2003 handbook. CMS has consumer-tested most of the handbook language. New information will be incorporated such as the five steps for patient safety.

1-800-MEDICARE Helpline (Attachment F):

- The 1-800-MEDICARE helpline expanded to 24-hour/7-day coverage by Customer Service Representatives (CSRs) in October 2001. The 24/7 coverage will continue year around.

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- During the period of peak call volume in the fall, CMS had seven call centers staffed by 1200 CSRs. There are currently about 600 CSRs.
- CMS changed the nature of CSR duties and training to enable them to be better prepared to answer a wider variety of questions. CMS is testing methods of training CSRs so that most questions can be answered at the most accessible level, and that they will know when and where it is appropriate to refer callers.
- CMS continues to modify the Medicare Personal Plan Finder (MPPF), a tool to help people with their health insurance decisions.
- The top five referrals from the 800 helpline are the Social Security Administration, Medicare Part B carriers, state Medicaid offices, durable medical equipment regional carriers (DMERCs), and Medicare Part A intermediaries.
- CMS is working toward building a "single desktop" for CSRs. The single desktop would provide CSRs access to all the contracted systems that provide information and service to people with Medicare. It would provide a more efficient process for answering questions and require fewer referrals.
- The top subjects of calls to the helpline in the fall of 2001 were verification of Medicare coverage, request for replacement cards, M + C, Medicaid, prescription drugs, and Medicare choices when a plan leaves.
- CMS will move to a web-based training tool for information intermediaries rather than sponsoring regional training programs. This will make the training more uniform and expand its reach.
- CMS will make databases available to information intermediaries with common interests such as coverage and local medical review policy.

Medicare.gov (Attachment F):

- Yearly page views have grown from 10 million in 1999 to 40 million in 2001.
- New services added in 2001 include Dialysis Facility Compare, Medicare Personal Plan Finder, tools to assist with frequently asked questions, and the ability to respond to email from website users.
- CMS is migrating to a new web host to improve performance.
- Nursing Home Compare data is being revised.
- The glossary was updated and a Spanish glossary was added.
- CMS will add additional information from the Consumer Assessment of Health Plans Study (CAHPS), the nursing home quality initiative, and health of seniors measures.

Nursing Home Quality Initiative (Attachment G):

- In April, CMS will publish comparative information in six states on a set of quality measures concerning nursing home residents.
- CMS selected the measures in concert with the National Quality Forum (NQF).
- The measures will be presented as percentages.

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- CMS is working with NQF to determine the best way to present the information to the public.
- The six pilot states are Florida, Colorado, Maryland, Ohio, Rhode Island, and Washington state.
- The measures for chronic care (long-term stay) patients are the percentage of residents who: need more help from staff doing daily activities; have certain types of infection in the nursing home; have lost too much weight; have very bad pain at any time or moderate pain every day over the last seven days; are reported to have one or more bed sores; and, are in physical restraints daily.
- The measures for post-acute care (short-term) patients are the percentage of short-stay residents: who have symptoms of delirium; with very bad pain at any time or moderate pain every day over the last seven days; and, whose walking has improved.
- CMS will conduct a publicity campaign to promote the pilot.
- Partners include state survey and certification organizations, consumer commissions, Quality Improvement Organizations, nursing home associations, nursing home patient associations, and nursing home ombudsmen.
- CMS intends to engage in similar quality comparison projects with other providers in the future.
- The NQF is grappling with the difficult issue of how to represent risk adjustment in nursing home quality measures.
- A member suggested that CMS make nursing home survey information accessible through the Nursing Home Compare database.
- A member stated that the NQF is seeking to increase consumer involvement in its work.
- A member suggested that CMS consider using employee retention rates as an indicator of quality of care.

Vulnerable Populations: Referring to the SHIP discussion, Ms. McMullan clarified that CMS defines vulnerable populations that SHIPs need to target as those who have barriers that affect their access to information because of language, literacy level, or location. Ms. McMullan said that it was difficult to quantify the percentage of the Medicare population that has one of those barriers. Another member raised the issue of including the 25 percent of people with Medicare who have cognitive deficits. Ms. McMullan explained that CMS will reach this population through caregivers.

Secretary's Advisory Committee on Regulatory Reform: DHHS Secretary Tommy Thompson has convened a federal advisory committee to examine how to reduce the burden of federal regulations within the Department (**Attachment H**). CMS and the Food and Drug Administration represent most of the regulations in DHHS. The Committee will convene four field hearings in Miami, Phoenix, Pittsburgh, and Minneapolis. The clarity of communication by CMS, especially beneficiary communication, is of interest to the panel.

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Ms. Margulis, a member of the Regulatory Reform Committee, gave an overview of the committee for information purposes. She said that the committee had 27 members and the Secretary is expected to appoint additional consumer representatives. The committee must complete its report by October 2002. The committee has designated four subcommittees to cover data and information, flexibility in regulations, communications and oversight, and coordination. Ms. Margulis chairs the Subcommittee on Flexibility in Regulations. That subcommittee is looking at how to remove obsolete regulations and requirements, how to better implement and evaluate rules, and how to adapt to marketplace changes on a timely basis. The committee's recommendations will be in three categories: those that can be implemented within six months, those that can be implemented within six months to one year, and those that would take more than one year to implement. Ms. Margulis invited the APME's input on the work of the Regulatory Reform Committee. She said that she had requested that the committee make the APME Annual Report part of its record.

Additional Member Comment: A member commented that CMS should display on its publications the state SHIP numbers as prominently as the 1-800-MEDICARE number.

[Whereupon at 12:33 p.m., the meeting was recessed, to reconvene at 1:45 p.m., this same day]

Medicare Education Research Update

Dr. Elizabeth Goldstein, Director, Division of Beneficiary Analysis, CMS

Dr. David Miranda, Social Science Research Analyst, CMS

Dr. Deborah Levesque, Director, Organizational and Health Behavior Change Projects, Pro-Change Behavior Systems

Dr. Elizabeth Goldstein opened the discussion on Medicare education research by discussing general findings from the assessment of the education program (**Attachment I**). The assessment began in the fall of 1998 when the national Medicare education program began. Its purpose was to obtain ongoing feedback about how CMS is communicating with people with Medicare and those who act on their behalf. The assessment was designed to evaluate each component of the education program: the 1-800-MEDICARE helpline, the Internet site, the REACH campaign, and the SHIP; and how well the components worked together. The assessments were conducted through such methods as surveys, focus groups, interviews, and "mystery shopping". CMS focused its initial assessment on six communities: Sarasota, Florida; Tucson, Arizona; Olympia, Washington; Eugene, Oregon; Dayton, Ohio; and Springfield, Massachusetts. Five of these communities were in the five pilot states in which CMS began the education program.

General Findings:

Knowledge Level:

- Large numbers of people with Medicare do not have a basic understanding of Medicare.

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- Thirty-eight percent say they know just about everything or all they need to know about Medicare.
- Thirty-one percent say they know little or almost none of what they need to know about Medicare.
- Seventy-nine percent know that Medicare without a supplemental policy does not pay all of their health care expenses.
- Fifty percent know that there are different health plan choices available in Medicare.
- Sixty-five percent know that out-of-pocket costs can vary by their health plan options.
- Fifty percent know that managed care plans can change their benefits and fees each year.
- Sixty-four percent know that joining a Medicare HMO limits their choice of providers.
- Sixty percent know little or none of what they need to know about Medicare HMOs.

A member asked what CMS considers as the most important aspects of the Medicare program about which people should know. Dr. Goldstein said that two examples of important concepts for people with Medicare to understand are: if you join a Medicare HMO, you are still in the Medicare program and Medicare does not pay for all of your health care needs.

Medicare information preferences:

People with Medicare generally do not seek Medicare information until they have a specific health care need. Beneficiaries can be viewed according to their information-seeking behavior as active, reactive, and passive. To receive Medicare information:

- Forty percent would prefer to talk with someone in person.
- Twenty-five percent would prefer to read a brochure or pamphlet.
- Nine percent would like to learn through television, radio, newspapers, or magazines.
- Three percent would use the Internet.

Use of information channels:

- Sixteen percent have called 1-800-MEDICARE.
- Most view the *Medicare & You* handbook as a reference document.
- Seventy-seven percent who remember receiving the handbook have at least skimmed it.
- Handbook readability has increased since 1999.

Use of quality information:

- Nine percent saw the quality comparison information in the *Medicare & You* 2000 handbook.
- Thirteen percent saw the benefit/cost comparison information in the handbook.

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Communities with health plan terminations:

- Six to thirteen percent volunteered that they had used the handbook to find out about their health insurance choices.
- When prompted, 32 to 42 percent said they had read the handbook.
- Most people get information from their insurance vendors.
- The second most used source was friends and family.
- One-sixth to one-quarter noticed health plan cost and quality comparison sections in the handbook.
- Nine to fourteen percent used the cost and quality information to help choose a new health plan.
- Many beneficiaries find the quality information interesting but find it difficult to understand. Some are skeptical about the data.

Differences in knowledge by racial and ethnic groups:

Racial and ethnic differences exist regarding:

- Those who know that Medicare does not pay for all health care expenses.
- Those who know that those who join a Medicare HMO are still in the Medicare program.
- Those who have called 1-800-MEDICARE
- Those who have access to the Internet.
- Those who have read the *Medicare & You* handbook either entirely or in part.
- Those who have seen the quality information in the handbook.

Initiatives:

Dr. Goldstein stated that CMS is planning two new surveys: a regional survey to help CMS regional offices target their education activities and a survey of new Medicare enrollees.

Conclusions:

CMS needs to refine its communication efforts to explain Medicare basics, support those beneficiaries who need help, adapt and customize frameworks, improve presentation formats, test products with consumers, and explore ways to promote informed choice.

Development of Materials and Strategies to Report Managed Care and Fee for Service Quality Performance Measures

Dr. Goldstein

Dr. Goldstein reported on the research of Dr. Shoshanna Sofaer, School of Public Affairs, Baruch College, New York (**Attachment J**). The purpose of the research was to support the development of materials and tools to assist people with Medicare in choosing among health plan options. The initial focus was to develop comparative quality information to support the choice process for health plans. The tools were for information intermediaries as well as people with Medicare. Dr. Sofaer classified the intermediaries along a continuum in terms of their relationship to beneficiaries. The continuum ranged from

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family and friends at one end to a website at the other. Dr. Sofaer conducted eight focus groups with family and friends and six with SHIP staff and volunteer counselors. Based on the focus groups and previous research, Dr. Sofaer developed and tested two versions of a short comparison booklet that SHIP counselors and others could use to help clients make decisions.

High level results:

Family and friends:

- They need information at trigger events such as the death or retirement of a spouse or when the beneficiary is newly enrolling or their health status declines.
- They generally report not having enough information and do not understand the information they have.
- They want clear, concise information from one source.
- They are unaware of the information that is available and how to access it.
- They are more concerned about cost, coverage, and access relative to quality of health options.
- They operate often in a crisis mode with little time to make decisions.
- They were more comfortable with recommending options about which they were familiar such as Original Medicare in areas with relatively low M + C penetration and managed care in areas of high penetration.

SHIP counselors:

- Quality issues were not a priority for their clients.
- Clients need help understanding Medicare basics before making decisions and using quality information.
- They prefer to give short handouts to their clients.
- They were concerned that in providing quality information, they would be making recommendations.

Conclusions:

- CMS must continue to find ways of presenting comparative information about cost, benefits, quality, and provider access.
- The challenge is to present the materials in a short, concise, easy to understand format for beneficiaries and others.

Hispanic/Latino Beneficiaries and Intermediaries: Promoting Quality in Health Plan Choice

Dr. David Miranda, CMS

Dr. Miranda spoke about two studies concerning Spanish-speaking or Hispanic/Latino beneficiaries and how to promote the use of quality measures for health plan choice (**Attachment K**). One study assessed the needs, barriers, and opportunities among the Hispanic/Latino populations. The second study focused on a particular site.

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Phase One: Assessment:

- The assessment approach included interviews, focus groups, and qualitative methods.
- The sites were New York City and Northern New Jersey, Los Angeles, Miami, and San Antonio.
- The research targeted beneficiaries of Puerto Rican, Cuban American and Mexican American descent.
- Few opportunities for quality information specific to the Hispanic population exist.
- Most were unaware of quality information and were uninformed of their health insurance status and choices.
- Information intermediaries and Hispanic/Latino-serving community-based organizations (CBOs) were also uninformed.
- Income-related concerns took precedence over quality of care.
- When researchers explained the existence of quality information, intermediaries showed great interest.
- Most community-based organizations, except those in Miami, did not have connections to the local SHIPs.

Phase Two: Pilot Project:

- CMS solicited invitations from SHIP sites.
- A strong SHIP was selected in Hudson County, New Jersey.
- The SHIP had difficulty reaching the large, diverse Hispanic population.
- The contractor developed a training manual for CBOs.
- The contractor produced a video that featured local actors representing sectors of the community. The video included conversations about Medicare, health plans, coverage options, and help with costs.
- It was helpful to have a third party make the connections between the SHIP and the Hispanic CBOs.
- It was helpful to involve the community in producing the video so that it addressed the community's needs.

Next Steps:

- CMS will evaluate the video and explore using it as a template for other areas.
- CMS will conduct additional research with providers such as nursing homes.
- CMS will conduct research with other vulnerable populations.

Application of the Transtheoretical Model to Informed Choice in the Medicare Population

Dr. Deborah Levesque, Pro-Change Behavior Systems

Dr. Deborah Levesque began her presentation (**Attachment L**) by explaining that Dr. James Prochaska founded Pro-Change Behavior Systems. Dr. Prochaska developed the transtheoretical model (TTM) of change with graduate students at the University of Rhode Island over the last 20 years.

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- TTM is an empirically validated framework that can explain or facilitate change.
- It produced high impact change programs for the entire population, not just those who are ready to change.
- It transfers to every population they have worked with.
- It is data driven.
- It has been applied to acquisition behaviors such as yearly mammograms and organ donation and cessation behaviors such as smoking.
- The model understands change as progress over time through a series of stages: pre-contemplation, contemplation, preparation, action, and maintenance.
- Stage of change is a better behavior predictor than demographic variables.
- Behavioral scientists facilitate progress by using the principles and processes of change that work best at each stage.
- The researchers are working in three phases: measure development and model testing; intervention development; and intervention training.

Phase 1 Accomplishments:

- Defined "informed choice" among people with Medicare as an annual review of their current health plan to see whether it meets their needs and if not, comparison of different plans to find one that may work better.
- Developed TTM measures for review and comparison of stage of change, decisional balance (pros and cons), self-efficacy, and 10 processes of change.
- Conducted focus groups to generate ideas, ensure cultural sensitivities, ensure the validity of questions, and test for literacy level.
- Administered the review and compared measures.
- Refined measures to chart the relationship between stage of change, knowledge and information seeking, and identify the principles and processes that facilitate stage progression.

Phase 2: Intervention:

- The goal is not to replace CMS materials but to prepare people to use them.
- They decided to focus on new enrollees.
- The interventions are a stage-based manual, a multimedia expert system, and train-the-trainer and counselor protocols.
- A media component informs beneficiaries about the TTM interventions and provides stage-matched messages.
- The tool teaches users about strategies they can use to progress to the next stage and then integrates information in a stage-appropriate fashion.

Phase 3: Testing:

- Four hundred and fifty people who have computers will be tested.
- Nine hundred without computers will be assigned to the TTM manual alone.
- For each group, there will be a control group that receives no intervention.

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- At one month after intervention, the participants will be contacted to determine whether they used the materials and their opinions of the materials.
- At six months after the intervention, their stage of change will be assessed along with their knowledge about Medicare and their satisfaction with their health plan choice.

**Public Comment
Ms. Caliman**

Noting that no one had signed up to give a comment, Ms. Caliman called for public comment. No one responded. She stated that written comments could be submitted for the record within the following three business days.

**Next steps
Ms. Cronin**

Ms. Cronin stated that the next meeting would likely be held in May. She asked members for suggestions for next steps. One member suggested that CMS conduct a study of people with Medicare to determine which kind of health options they want. Another member suggested that linking the 1-800-MEDICARE number with other information numbers such as 211 might become an issue. Another member suggested an update and role for the APME in giving feedback on consumer messages about the nursing home quality initiative. A member suggested that CMS survey incoming and current APME members concerning their ideas for agenda topics.

**Adjournment
Ms. Caliman**

After inviting members to continue to be involved in the work of the APME, Ms. Caliman adjourned the meeting at 3:48 p.m.

Prepared by:
Nancy M. Caliman, Designated Federal Official, Advisory Panel on Medicare Education
Division of Partnership Development /Partnership and Promotion Group
Center for Beneficiary Choices
Centers for Medicare & Medicaid Services

Approved by:
Carol Cronin, Chairperson
Advisory Panel on Medicare Education

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Attachments

- A.** *Federal Register* Notice, January 25, 2002 (Volume 67, Number 17, Pages 3720-3721).
- B.** Sign-in Sheet.
- C.** Meeting Summary, October 25, 2001 Meeting of the Advisory Panel on Medicare Education.
- D.** Annual Report, Advisory Panel on Medicare Education, January 31, 2002.
- E.** The State Health Insurance Assistance Program: A National Overview.
- F.** Update on www.medicare.gov and 1-800-MEDICARE.
- G.** Nursing Home Performance Measures: Public Reporting Initiative.
- H.** Secretary's Advisory Committee on Regulatory Reform: News Release, Charter, and Schedule of Meetings.
- I.** National Medicare & You Education Program Research.
- J.** Development of Materials and Strategies to Report Managed Care and Fee for Service Quality Performance Measures.
- K.** Hispanic/Latino Beneficiaries & Intermediaries: Promoting Quality in Health Plan Choice.
- L.** Application of the Transtheoretical Model to Informed Choice in the Medicare Population.