Centers for Medicare & Medicaid Services
National Medicare Education Program Webinar Meeting
Moderator: Jill Darling
September 27, 2017
1:00 p.m. ET

Operator: Good afternoon. My name is Matthew, and I will be your conference operator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services National Medicare Education Program Webinar Meeting.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session.

If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your questions, press the pound key. Thank you. Dina Payne, you may begin your conference.

Dina Payne: Thank you, Matthew. We appreciate you helping us moderate today's call. Hello, everyone, I'm Dina Payne, Partner Lead in the Partner Relations Group in the Office of Communication at the Center for Medicare and Medicaid Services.

I am filling in for Susie Butler, Director of the Partner Relations Group, and I would like to welcome you to today's National Medicare Education Program Call.

Now, before we begin, I would like to go over a few housekeeping items. For the record, today's meeting is being recorded and the audio recording and presentation materials will be posted on the NMEP website.

This meeting is not intended for the press and remarks are not considered on the record. If you are a member of the press, you may listen in, but we ask that you please refrain from asking questions during the Q&A portion of the call. Should you have any inquiries, please feel free to contact the CMS press office at press@cms.hhs.gov.

The presentations and audio recording of today's meeting will be posted on the CMS NMEP web page in about one week from today. After the materials have been posted, we will e-mail you a link to access the materials on the NMEP website.

Again, I would like to thank all of you for joining us for today's call. We recognize that trusted organizations like yours are on the frontline working to connect individuals to Medicare information, health resources, and services and we hope this afternoon's presentations will assist you in your important work.

Now, I would like to introduce our speakers. First, we will have Catherine Rippey, Medicare Beneficiary Ombudsman in CMS' Office of Hearings and Inquiries, and she will discuss the role of the Medicare Beneficiary Ombudsman, the Ombudsman's general focus areas, and how the Medicare Beneficiary Ombudsman coordinates with various external and internal partners to monitor the Medicare beneficiary's experience with the Medicare programs.

Next up, we'll have Lisa Carr, Health Insurance Specialist in the Partner Relations Group in CMS' Office of Communications, and Lisa will provide an overview of the toolkit created by the HHS Partnership Center to help equip (faith-based) and other community organization leaders to address the opioid epidemic and also help those who have been impacted by opioids. Lisa will also discuss opportunities to engage in social media with community coalitions.

Following Lisa's presentation, we'll have Erin Pressley, Director of the Creative Services Groups in CMS' Office of Communications, who will provide a presentation about the new Medicare card. In addition, Lisa will also provide information about the new card design, card research, outreach plans, and fraud awareness activities.

Next up, we'll have Charles Padgett, Health Insurance Specialist and CMS' Center for Clinical Standards and Quality, who will discuss the new CMS hospice compare website, which was launched on August 16, 2017. Charles

will also provide an overview of the information contained within the website that consumers may find helpful when choosing a hospice.

And lastly, we'll have Jason Green, Chief Advisor and Deputy Ethics Counselor in the Department of Health and Human Services Office of Medicare Hearings and Appeals. Jason will provide a general overview of the benefit claim and appeals processes under Medicare Part A, B, C and D with special attention to Medicare beneficiaries, including enrollees in Part C and Part D as appealing parties.

Again, we'll take your questions after each presentation. Now, it's my pleasure to introduce Catherine Rippey.

Catherine Rippey: Thank you very much, Dina. And good afternoon or good morning, depending on where you are joining us from today. I want to thank you for including me on the agenda, Dina and Jill, today.

I appreciate getting the opportunity to say hello and to say thank you to all of our partners who are on the line for all the work that you do to support our Medicare beneficiaries.

I know we got a pretty full agenda today it looks like. So, I'm just going to talk for a few minutes. I wanted to introduce myself first of all and then go over briefly what the role of the Medicare beneficiary ombudsman is for and how we might coordinate together as an agency in our external partners to assist and support our Medicare beneficiaries.

Next slide. So, simply put, the rule of the Medicare Beneficiary Ombudsman or MBO as we call it was established by Congress to receive and respond to beneficiary inquiries and complaints to provide guidance to beneficiaries regarding how to file an appeal and then also to listen to the beneficiary and utilize information and feedback from beneficiaries and partners to provide recommendations for improving the administration of the Medicare program.

This role actually was laid out in the legislation that also gave us Part D, our drug benefit, and I have been in the role for officially just a little over a year now. Prior to that, I've worked with CMS for about 11 years out of our CMS

Kansas City regional office in fields of case work regarding Medicare Advantage and Part D and then also on the marketplace Affordable Care Act side.

So, when we look at the role of the MBO, the Medicare Beneficiary Ombudsman, we're really kind of continuing to evolve the role and the function to establish a beneficiary-centric approach.

Currently, I concentrate my efforts on four primary areas that you see on the slide there. Those include partner initiatives, inquiry management, beneficiary assistance, and then also I have an annual report to Congress that we write.

So, my efforts to address beneficiary concerns or insights are guided a lot from feedbacks from partners like you. Obviously, I'm speaking with beneficiaries and their advocates or caregivers but also like to have an ongoing open communication with our other partners so that I can get an understanding of what concerns there may be with beneficiaries and get that insight in the programs.

One of the primary objectives of this role and what I'm focusing on is how our beneficiaries and our other customers are experiencing the program. So -- and that would be regardless if they're getting their Medicare coverage through our traditional fee-for-service program, through a Medicare Advantage plan. We know the majority of our beneficiaries do enroll in a Part D plan.

So, we're really starting to engage and look heavily at what our customers experience looks like and we've been using a variety of tools to do that, and we'll continue to do so as we look at the customer's journey and how the beneficiary gets where they need to be and how are they finding out the answers that they are seeking.

So I essentially act as an advocate for the beneficiary to bring attention back to internal policy makers at CMS when there are suggestions for improvement. I, however, always want to point out that I don't change policy.

I don't make policy or write policy. We have many talented folks within CMS who (inaudible) prohibits asking if (inaudible) payment and that kind of thing (inaudible).

But as far as the role and the primary focus areas go, with partner initiatives, that includes events like this call. We have quarterly stakeholder conferences that I hold in conjunction with our competitive acquisition ombudsman who handles the DME competitive bidding program.

Certainly, we hold adhoc meetings with our advocates like the Medicare Rights Center, for instance, and certainly, always available to meet with partners regarding Medicare beneficiary concerns.

Through the inquiry management process, I work with staff all throughout CMS (so) in our office in Baltimore and then also throughout our CMS regional offices utilizing the data from inquiries and complaints that we have to identify if there are certain concerns and get at the root causes of those.

So, even though all complaints may not be coming directly into me as the ombudsman and our supporting staff, we're collectively working with all of the different components throughout the agency, including our call center folks through 1-800 Medicare to make sure that we're all monitoring and providing feedback to each other on what we find.

I mentioned the annual report to Congress. And basically, that just goes out in details what the MBO's fiscal year activities have been, certain initiatives, also gives me the opportunity to provide recommendations to Congress, for instance, if we think there are identified improvements that could be made that would require legislative changes.

And then most important is the Medicare beneficiary. So, I like to speak with our beneficiaries directly and provide assistance when I can. Obviously, as I mentioned, we have a large cadre of people who assist in that effort since we have nearly 60 million Medicare beneficiaries.

It certainly takes a village to assist. But engaging directly with the Medicare beneficiary is something I really enjoy because it allows me to see the

program through their eyes and so then I can adequately represent their view back to the agency.

So, with all of that said, on the next slide, we go through just as a high level overview of the consumer assistance process that we have at CMS. I've mentioned a couple of times now how important those other (arms) as customer service and customer experience are to the program.

And I often get the question, so what do we send to you as the ombudsman, what do we send to the CMS contacts we have in our regional office or out in Baltimore.

So, I just kind of wanted to briefly go through this. The graphic highlights some of the key touch points that a beneficiary or caregiver or partner might experience and typically, of course, this comes in with the question that the beneficiary has.

We know we have a vast network of our state health insurance assistance programs who may be able to assist the beneficiary or caregiver right away without even contacting CMS based on the training or resources that they have.

But we also may either go from the (SHIP) or go directly to 1-800 Medicare with their inquiry or question. And of course, we have our 24/7 assistance through 1-800 Medicare to address members or beneficiaries concerns, rather, and general Medicare question. Of course, from 1-800 Medicare, the complaints or inquiry can take a variety of turns, so to speak, as it's directed to the correct (entity).

That could be to the Medicare beneficiary ombudsman as our CSRs at 1-800 Medicare can facilitate referral in that regard. It may go off to a CMS regional office. They may share information with the Medicare administrative contractors if it's original Medicare fee-for-service issue.

They may also contact the Medicare plan or the Part D plan via a complaint tracking module that we have. So, the complaints or inquiries can take a

number of turns, but just kind of wanted to show you this to emphasize how we all work together than to share that information and data.

Again, a couple of reminders, if a beneficiary has an issue with their Part D plan or their Medicare health plan, it's often the best place to start with the plan as those entities have at their disposal the claims and payment information, but I just wanted to kind of show this to you.

I think bottom line I encourage you to continue to maintain those relationships that you've built with CMS as we do all work together. But certainly, always would invite you to contact me as well if you have questions or concerns. And the last slide of the deck has my direct contact information.

And with that, thanks again for having me on the call today, and I'll turn it back over to our host.

Dina Payne: Thank you so much Catherine, for this wonderful information. In lieu of questions, we would like to invite our listeners to contact you via the e-mail or telephone numbers that you have listed if they have additional questions or would like additional information about the Medicare Beneficiary Ombudsman. And again, thank you so much for this information.

Catherine Rippey: Thank you.

Dina Payne: And now, it's my pleasure to introduce Lisa Carr.

Lisa Carr: Wonderful. Thank you so much, Dina. I'm so glad to be with you all today.

Dina Payne: Happy to have you.

Lisa Carr: I -- great. You know, my slides are -- it looks like they're getting uploaded. So, we're excited to be presenting about the opioid toolkit.

And if you can go ahead to the next slide, the CMS partners with the HHS Partnership Center, also known as the HHS Center for Faith-Based and Neighborhood Partnerships, they have produced a toolkit called Hope and Healing, a practical toolkit for faith and community leaders in the face of the opioid epidemic.

The link to the toolkit is right below there on your screen, https://www.hhs.gov/about/agencies/iea/partnerships/opioid-toolkit/index.html and it's a short toolkit. It's only about 10 pages or so with great resources. I'm going to highlight the toolkit for you today and some of the key points that we think would be helpful for you and I'll end up with some social media thoughts and next steps.

So, we know that each day we are losing more than 91 Americans to opioid overdoses. In 2015 alone, more than 52,000 people died of drug overdose in the U.S., the majority of them from opioids. The majority of deaths about 33,000 people, died from opioids.

Faith and community-based organizations, they are instrumental partners in addressing and preventing public health issues.

The toolkit from the U.S. Department of Health and Human Services Faith-based Office outlines the ways in which faith and community organizations can support prevention efforts and reduce risks, provides support to those in and seeking recovery and saves lives and prevents future generations from harm.

If we go to the next slide, you'll see there are six ways that we can be active in making a difference in our communities. There are six practical ways that your community may consider bringing hope and healing to those in need.

The first is open your doors. Second is increase awareness. The third is build community capacity. The fourth is rebuild and restore. The fifth is get ahead of the problem. And the sixth is connect and collaborate. And I'm going to go into more detail on each of these in the following slides.

So, if we go to the next slide, open your doors. We know that finding a supportive community is essential to ongoing recovery. The process of recovery is supported through relationships and social networks.

Communities can offer to host programs like Alcoholics Anonymous, Narcotics Anonymous, Celebrate Recovery, or other self-help support group.

Programs like these help diminish the isolation suffered by those with addiction. It connects them to others in recovery and it supports those receiving medication-assisted treatment or MAT as part of their recovery.

Boldly post your recovery program or self-help support group schedule, list them on United Way 211or drugabuse.com websites. Let people know your community is supportive and committed to recovery.

Drive members of the community who lack access to transportation to treatment and recovery support service programs. Be a resource and connect people to the help that they need.

Create an easy to access resource center or a wall on your Facebook page with information that might include your local AA or NA meetings, your local Al-Anon meetings and Alateen meetings, perhaps the Substance Abuse and Mental Health Services Administration or SAMHSA's Behavioral Health Treatment Services Locator, and I also want to add SAMHSA's National Helpline, which is 1-800-662-HELP, and there's a TTY number for people with hearing challenges, 1-800-487-4889.

There's free and confidential help in English and Spanish 24 hours a day, 7 days a week, which is a great resource. When offering public or congregational prayer, particularly prayers for the sick, please pray for people who suffer from addiction and opioid use disorder.

Now, if you go to the next slide, the next step is to increase awareness. This is another way that you can make a difference in your community. Provide educational opportunities that create understanding and encourage compassion.

Community members need to understand addiction in order to create a culture of acceptance and support. Once addiction is understood as a chronic condition, not a personal failing, stigma and shame can be replaced by compassion and hope.

As a pastor in West Virginia noted, churches are not neutral bystanders. What they don't say is just as important as what they do say.

Your community can partner with your local public health office, hospitals, community health centers, or non-profit service organizations to host educational events on medication-assisted treatment. Encourage discussions and training around evidence-based medication assisted treatment (MAT) for opioid addiction.

Your community can host educational events on addiction as a disease, a long-term chronic condition, helping community members understand the need for long-term support for people in recovery.

Your community can educate the public on pain management. A knowledgeable consumer is important. Know to ask, is it that an opioid, is it necessary, are there alternatives such as non-medication pain relief or self-management programs for my pain.

Your community can educate the public on adverse childhood experiences or ACEs and trauma-informed approaches. Early stressful or traumatic events increased risk for substance abuse, can challenge recovery efforts and underscore the importance of prevention like supporting (youth) and strengthening families.

Your community can educate the public on safe drug disposal. 50.5 percent of those who abused prescription painkillers, they obtained them from friends or family. Learning about and promoting safe drug disposal sites can raise awareness and reduce the supply of opioids getting into the wrong hands.

And finally, your community can educate about Good Samaritan laws, invite local law enforcement officials to talk about the laws in your state that may protect those providing and calling for help.

Now, if you go to the next slide, you'll see the next practical way your community can help people in need: build. Community capacity. Your

community could offer training programs to build the capacity of communities to respond.

We need to make sure people struggling with addiction get treatment. It can make a huge difference. Being able to refer people to the right treatment at the right time and navigate systems of care, it will save lives.

Across the country, lay leaders and faith and community organizations, they are being trained to make referrals to treatment, respond in an emergency, and provide ongoing support groups for those in recovery and living with addiction.

Your community can partner with local public health offices, treatment facilities, hospitals, community health centers, or nonprofit service providers to deliver capacity building trainings, which might include (1) screening, brief intervention and referral to treatments (SBIRT), a public health approach to the delivery of early intervention and treatment to people with substance use disorders and those at risk of developing these disorders.

Your community can provide training on how to navigate the substance abuse disorder system of care. Broaden your community's understanding of the types of substance abuse disorder treatment services that are available in your community.

Your community can provide training on is motivational interviewing, a counseling approach that seeks to facilitate and strengthen an individual's motivation to change their drinking or other behavior by aligning the change in behavior with their life goals.

Your community can help with emergency response. Provide training on how to recognize overdose symptoms and administer naloxone, an opioid overdose reversing drug that is pulling thousands of Americans from the brink of death. And I do know that many congregations are doing training in how to use this drug in an emergency situation.

Your community can partner with organizations to develop peer recovery models. By sharing their experiences, peers bring hope to people in recovery and promote a sense of belonging within the community.

Your community can give training on mental health first aid. You can provide courses that give people the skills to help someone who is developing a mental health problem or experiencing a mental health crisis.

And finally, your community can partner with organizations to develop training on trauma-informed approaches and trauma-specific interventions. These trainings provide critical awareness of the linkage between recovery and resilience for those individuals and families impacted by trauma.

Now, if we go to the next slide, the fourth practical way we can help those in need is Rebuild and Restore: support individuals and families in rebuilding their lives. Drug addiction makes it hard to function in daily life.

Drug addiction affects how you act with your family, at work, and in the community, and it is hard to change so many things at once and not fall back into old habits. Recovery from addiction is a life-long effort. The lives of individuals and their families can be dramatically altered, and too often destroyed by addiction.

Faith and community-based organizations are poised to support what the Substance Abuse and Mental Health Services Administration has identified as the four major dimensions that support a life in recovery. The first is health. The second is home.

The third is purpose. And the fourth is community. Your community can restore these life-giving essentials by providing help with employment readiness, housing, transportation, food, clothing, and child care and support for recovering persons and their families as they overcome the consequences of addiction.

Your community can help by designating a community leader to connect people to a central service, through a created database such as United Way 211. They can help by offering life readiness or coaching programs for re-

entering formerly incarcerated citizens. And your community can help by coaching families on financial management.

Now, if you go to the next slide, the 5th way you can help people in your community is to get ahead of the problem by focusing on prevention, especially for youth. Close to 45 percent of high school seniors use marijuana daily and 28 percent of youth have tried cigarettes by the 12th grade.

In addition, alcohol remains the most widely used drug by today's teenagers. But did you know that prescription drug medications are some of the most commonly misused drugs by teens after tobacco, alcohol, and marijuana?

Communities may also consider targeting some of their efforts on youth, not only because of the path of experimental substance abuse may lead to life changing and potentially devastating consequences but also because young people may be suffering in homes where addiction is present.

Consider offering programs and services that support families and empower youth that (1) Focus on prevention and offer positive parenting programs and programs that support strong relationships and families; (2) offer mentoring, to support children and parents in active addiction; (3) gather resources, donate clothing and other necessities like cribs and car seats and provide support for local foster families as they meet the need to foster children.

You might want to host a faith-based recovery and support program such as The Landing or Teen ChallengeUSA or similar programs for young people.

You might want to create a place on your website or on Facebook with resources provided in the final pages of the toolkit such as NIDA's Teen Talk, , What To Do if your Teen or Young Adult has a Problem with Drugs, Get
Smart about Drugs, or Above the Influence, which is a really popular resource.

You can help ensure that all children and youth have access to safe, stable and nurturing relationships and environments so that all people can reach their full life potential.

Now, let's go to the last practical way your community can help people in need. This is the last suggestion we have for you today. You can connect and collaborate, join local substance abuse prevention coalitions to inform, connect, and strengthen your efforts.

The Substance Abuse and Mental Health Services Administration has created a document, One Voice, One Community: Building Strong and Effective Partnerships Among Community and Faith Organizations. The document states that no single organization or person can address the multitude of services needed to help people affected by mental health or substance abuse conditions. The best sources are the people who live, serve, and work in the community, and the best results are often seen when they undertake such actions together.

To join a coalition visit the Community Anti-Drug Coalitions of America, which is also called CADCA. Join or start a recovery community organization or contact your local public health department, HHS regional offices, or SAMHSA regional offices, and connect with diverse partners in collaborative, cross-cultural, and comprehensive substance abuse prevention efforts that make sense for your community.

You might want to lend your organization's health "assets" to the effort. Whether you have space for a support group to meet, can hold educational forums, maybe coordinate volunteers to help transport people to treatment and recovery support services or get help with job interviews. Your community's contribution can be essential.

Review SAMHSA's toolkit, One Voice, One Community, Building Strong and Effective Partnerships among Community and Faith-based Organizations, and consider recognizing national observances related to substance abuse treatment and prevention.

This is National Recovery Month in September, invite people in recovery to help with the planning. And May is National Prevention Week, an annual health observance dedicated to increasing public awareness of and action around, mental and/or substance abuse disorders.

Now, if we go to the next slide, you'll see some resources. These are some resources that are in the toolkit. All of the information that I provided for you today is in the toolkit.

And if you go to the next slide, you'll see some other key information, like contact information. If you have questions or have any suggestions or thoughts, please e-mail me. That's the best way to get in touch with me.

We are engaging in social media. The way we're doing that is with the HHS Partnership Center. They created a hashtag. It's #PartnersInHope, one word, PartnersInHope. The HHS Partnership Center is currently engaging in a live stream event on opioid recovery and prevention.

They are following up this event with a number of social media events and they welcome our engagement. If you want to get further engaged with the next steps of our social media with the HHS Partnership Center, please send me an e-mail at lisa.carr -- C-A-R-R as you can see on the screen – at cms dot hhs dot gov and I look forward to following up with you. My address is Lisa.Carr@cms.hhs.gov.

Thank you so much. I'm sorry I can't take questions today. I'm at a conference, but look forward to taking your questions by e-mail. And I will turn it back to Dina.

Dina Payne: Thank you so much, Lisa, for this valuable information. Just to reiterate, if you have questions for Lisa, or if you would like additional information, again, her contact information is on the screen. You can feel free to contact her at lisa.carr@cms.hhs.gov or at 202-690-5742. Thanks, again, Lisa. Now, it's my pleasure to introduce Charles Padgett.

Charles Padgett: Thank you very much. And a big thank you both to Jill and Dina for giving me the opportunity to present on hospice compare today. We can move on from the title slide here, if you would.

Hospice Compare, we just recently launched this new CMS website on August 16th. And today, CMS is sharing this information about hospice providers to permit the public to compare providers on measures of quality of care.

The Hospice Quality Reporting Program was established under Section 1814(i)(5) of the Social Security Act, which also requires the secretary of Health and Human Services and by proxy, CMS, to publicly report the quality data that we collect from hospice providers on the CMS website.

And when I refer to hospice providers, I'm referring to hospice providers across the country. And in fact, we have over 4,000 hospice providers that submit quality data to CMS.

Next slide. And the (goal) of Hospice Compare is really to help consumers and not just patients or perspective patients of hospice but their family members and caregivers also healthcare facilities that might be helping to refer patients, allowing them to compare hospice providers on their performance and assist them in making decisions that are right for them. We have lots of information on the Hospice Compare website including a list of helpful questions to ask perspective hospice providers when trying to choose a hospice.

Next slide. The hospice item set is actually the data collection instrument that's issued by CMS and hospices are required to complete and submit that data collection instrument to CMS.

And that data is collected at both admission and discharge for each patient within the hospice system. And it captures really important information about the patient care that was given by the hospice.

Currently on the Hospice Compare website, there are seven quality measures, which are all endorsed by the National Quality Forum that we report their performance -- we report hospice agency's performance on these quality metrics on the Hospice Compare website. And those quality measures are treatment preferences.

We look at the (recent) values that the patient believes in values that are addressed by the hospice, pain screening, pain assessment, dyspnea screening, dyspnea treatment as well. And also patient is treated with opioids (or a given) bowel regimen.

In addition to that, the Consumer Assessment of Healthcare Provider and Systems or what we call CAHPS Hospice Survey Information will be displayed on Hospice Compare during a subsequent quarterly data update that's going to occur in winter of 2018.

Next slide, please. So, this is what we call the landing page of Hospice Compare. So, when you -- you can go do a simple Google search to get to Hospice Compare. You can just search for Hospice Compare, the first or the second return that you get when you search on Google. It's also accessible from several CMS' webpage and Medicare.gov webpages. And this is the first page that any user of Hospice Compare will come to.

And I just want to sort of go for the layout here. At the top, you'll see there is sort of the search mechanism that's located there. Below that where you see Learn More, right below that, there's a sort of blue button that says, "Here are some good things to know about Hospice Compare -- about hospice care."

And what we have there is just some important information about hospice care basics, what kind of services hospices cover, where hospice care usually takes place, that sort of information, but just good basic information to help consumers have a better understanding of the how hospice care works and so forth.

Below that, we have three areas of spotlight area, tools and tips area and additional information. Under the spotlight area, we entered the question why Compare Hospice agencies, hospice – and we also have a hospice care (basics) link and this is where our checklist, our list of questions that consumer may want to ask hospice providers when they're searching for the provider that might fit them best.

Under the tools and tips area, we have area – you know, links to – that folks can use to find out how Medicare coverage works. You can file a complaint

about hospice services there and also there are links – there's a link to be able to go to our other Compare websites there.

And then under additional information, there's some direct links to the actual datasets for researchers and so forth. But as I said, there are two – the search mechanism is at the top. There are two ways that we allow consumers to search for a hospice.

One is by the name of the hospice, often when people are looking or going into hospice, they're given the name of a hospice by a family member or a friend that has used hospice services in the past or they are given the name of a hospice by a healthcare provider.

So, you can search by the name of the hospice itself or you can search by the ZIP Code, city, state or just the state and you can combine that search as well. Next slide please.

I also just wanted to point out that the Hospice Compare website is also optimized for viewing on both the tablet format, electronic tablet format and a smart phone or cell phone format.

And when you view in these sort of formats, some of the information is a little bit more compressed or you may have to scroll a little bit more to get to it but all of the same information is available on both of those formats. Next slide.

This slide is looking at what you will see when you perform a search on the Hospice Compare website. What you'll get is a page of returns and it will be listed there for you and then if you look in the upper right hand corner, you'll see there's a page number, so it will list the number of pages that return related to the search that you did. So, you may not see all of the hospices on the first page but you may have to go to a second page.

And at the bottom it says, for example, showing 1 to 13 – of 13 results. So, it does give you the total amount of results and it lists each of the hospices here. So you can do two – one of two things here or you can do two different things here.

You can actually click on one of the names of the hospices if you're interested or you can click the green button that you see here related to one of the hospices and actually add them to Compare which means you're choosing to compare that hospice with other hospices.

And during any given session, you can compare up to three hospices at a time. It will not allow you to compare four. You'll get a warning message if you try to add four. It will ask you to remove one of the three that you previously selected but what that allows you to do is look at all of their data sort of side by side and easily compare their performance on the quality measures that we post publicly. Next slide please.

So this slide is showing you exactly that, sort of what it looks like when you choose to compare three hospices. At the top, you'll see each of the hospices and again from this page you could choose to click separately on any one of those hospices to see their data separated out, just for that hospice.

Or as you scroll down, you'll be able to see – we list on the left hand side of the page the actual quality measure and then we list the scores for each of the three hospices that you chose to compare.

And then on the blue box, in the blue box on the right hand side on the bottom you see the national average. And so that's average for all hospices across our nation, so you can compare to any of the scores to that as well. And not only do we list in a sort of a table format like this but we also listed in a graphic format.

So if you were to choose the blue button that says graph, you would be able to look at each of their scores in a graphic format which is a little different and it's more of just a – maybe easier visual way of viewing the data that's available here to you. Next page please.

This page is showing you what it looks like if you choose to just look at one individual hospice at a time. You can add them to your favorites, so you can sort of choose favorites and if you're going to hospices and you want to keep an eye on a couple of them or keep a list of the ones you're interested in, you can add them to your favorites there.

But all of the data for that hospice will be available when you choose to look at one separately including their location, all of their demographic data, their profit status and whether they're for-profit or not for-profit hospice. And then, you'll be able to look at their data by itself for that hospice that you scroll down on the web page. Next slide please.

So here, we list some additional resources where you can find additional information about Hospice Compare. We're really excited to have released this new website and make this available to not only CMS beneficiaries but the public at large and – as well as hospice providers, it's a useful website for them as well.

We have a Hospice Quality Reporting web page which you can link to directly from the slides and there's more information about Hospice Compare there.

We also list the requirements for our quality reporting – reporting program for hospices and all of the data they are required to submit to CMS. And then, we list links to help desk here for providers where they can go to get certain types of questions answered. And that's all I have today. I'll be happy to take any questions.

Dina Payne: Thank you Charles so much for this valuable information. Before we turn it over to our listeners for their questions, I actually have just a few questions for you.

Charles Padgett: OK.

Dina Payne: I know that you mentioned that some hospices have noted that they're finding differences in measure scores between the CASPER Quality Measure report and the data on Hospice compare, could you address the reason for the differences?

Charles Padgett: Sure, sure. So just to explain a little bit, so for providers they have reports that are available to them within our – the CMS system in which they can sort of go in and look at their quality data.

And so what Dina has asked me is some hospices are seeing a difference in what they're seeing on that website on their report versus what they're seeing on Hospice Compare when it's publicly posted.

And the data that's included on Hospice Compare for the August 16, 2017 launch and also that will be included for the future, November 17 refresh of data reflect data that was included on their provider preview reports that were released on June 1st of 2017 and August 29th of 2017 respectively.

Now their CASPER reports or their CMS reports are they can choose to run them whenever they want and they enable hospice providers to view and compare their performance to national comparison groups at any time for reporting period of their choice.

And data on those reports are updated frequently and reflect all (HHS) data that was submitted, modified or inactivated for up to 36 months after the date of that assessment. So if it was an assessment – an admission assessment or a discharge assessment, they can modify that data for up to 36 months.

And when they're looking at the CMS reports, they're going to see any modification they made to that data is going to be included in the measure calculations you're seeing there. However, modifications or inactivations that are made after actual freeze dates that we post for hospices will not be reflected on the Hospice Compare site.

So, they have deadlines by which they must submit all their data and make any modifications to data before it gets publicly posted. And so on one report, on the CMS report, they're seeing data that they can continue to make modifications to and on the Hospice Compare website they're seeing the data that they had to submit prior to the given deadlines.

And so that's the difference there but just – one more caveat, with that data that's listed on Hospice Compare, it will reflect any subsequent modifications that hospice made to their data beyond these freeze dates that I'm talking about. Only those modifications will not show until the next quarterly refresh on Hospice Compare.

Dina Payne: Thank you. Now you mentioned refreshes of Hospice Compare, when are the upcoming refreshes and will hospices be able to preview the data before public reporting and what data will the new refresh include?

Charles Padgett: OK. So, the next quarterly refresh will take place in November of this year in November 2017. And following that, we'll have quarterly refreshes that occur in February of 2018, in May of 2018 and in August of 2018. And as for the preview of data, hospices are able to see their data before it gets publicly posted on Hospice Compare and hospices are given the opportunity to review their data.

There's a three-day preview period that they participate in and during that period they have the opportunity to contact CMS with any questions or potential issues they see with their data.

And so we work with hospices throughout that preview period to make sure that their data is correct and in fact the data that they're seeing is what is supposed to be there and what should be going up on the Hospice Compare website.

And as far as the data is concerned, the next quarterly refresh which is going to take place in November will reflect patient's stays, discharge between January 2016 through December 31st, 2016.

The hospice quality measure, program measure scores are based on this data, were included in the hospice preview report that were just issued at the hospice is August 29th. So, we're currently in this 30-day preview period I talked about and hospices are now submitting those sorts of inquiries to CMS regarding their quality performance data.

Dina Payne: Great, thank you again Charles. I know that this information will be extremely helpful to our listeners and I would like to open the line for questions from our audience and at this time I'd like to ask the moderator to please explain the Q&A process.

Operator: Certainly. And at this time, I would like to remind everyone in order to ask a question, press star then the number one on your telephone keypad.

We'll pause for just a moment to compile the Q&A roster. Again if you would like to ask a question, press star then one on your telephone keypad. We have no questions at this time.

Dina Payne: Thank you Matthew and again thank you Charles for this information.

Charles Padgett: Sure, thank you.

Dina Payne: Next, I'm happy to introduce Erin Pressley.

Erin Pressley: Great, thanks Dina and thanks for having me here today. I wanted to talk a little bit about our new Medicare cards and just walk through some of the recent information that goes over what we've been working on. I'll start with a little bit of background information and some of you may have heard this before.

So, my apologies if this is not new to you but I just like to start with this because we're finding more and more – as people are becoming aware about new Medicare cards, we have different levels of knowledge coming in to some of these briefings.

Basically just as a reminder, the Health Insurance Claim Number or HICN is what we use now on the Medicare program as the beneficiary's identification number, and we use for that processing claims and determine eligibility.

Not only does CMS use that but also the Social Security Administration and the Railroad Retirement Board and all of our many other entities that we interact and do business with and share information with.

So, the MACRA of 2015 actually required us to change that HICN, that Social Security-based number and remove it from the Medicare cards to address risks – or reduce the risks for this currently with beneficiaries around medical identity theft.

So of course you're familiar with the amount of fraud and identity theft with this when something is available with the Social Security Number on it. We've been warning beneficiaries for many years to protect that number and so this log really required us to remove that number as the identifier and replace it with something safer.

It also requires that we mail out new Medicare cards to every person with Medicare that shows them their new number no later than April of 2019. And we just like to remind folks that this is just a change in the number in the card, it's not a change in any way for Medicare benefit.

So, it's important for people with Medicare to know that their new cards do not in any way signify a change in their benefit. On the next slide there is a picture of what the new Medicare card will look like. We released this a little over a week ago now.

You'll see that it's very similar but it is distinct enough for people to be able to tell the difference between the new card and their existing Medicare card. And the new number is, again, different from the current number because it's not based on their Social Security Number but it's also has a few more characters.

It is an alphanumeric number and certain key positions in the number will always be alphabetic. It's also a non-intelligent number. So with their current Medicare number, their current HICN, there are what I like to call you need the secret decoder ring.

But there are certain places where you can tell by the letter how the person is eligible for Medicare whether it's their own Social Security Number and benefits, whether it's based on the family member or whether they're eligible through the Railroad Retirement Board, those types of things. These new numbers will not tell us any information like that, so there's no sort of background behind these letters and numbers.

A couple of more things about the new card design, it's important I think to know that we did consumer test this with people with Medicare. Starting last

fall, we went out into the field with about 10 different designs that were possibilities that we were considering for the new Medicare card.

It really sort of run the gamut in terms of the design including cards that were the red, white and blue, the current color scheme as well as some, what I'll say are more modern-looking cards and had different color palette.

There was – actually not surprisingly based on what we know about people with Medicare, there was a strong preference for them to maintain a red, white and blue Medicare card.

They have very strong ties to that particular color scheme. They also wanted to make sure that they weren't confusing it with some of their other cards from other health plans or insurers. And so the red, white and blue really stand out to them as their Medicare card.

We also wanted to make sure that the text of the card remains easy for folks to read at a glance and also to be able to copy or scan at providers' offices.

So, we want to keep the pertinent information on a white background to make that scanning and copying easier. The card is slightly smaller than their current card. We wanted to match the size of a standard credit card, so that it fits easier into their wallets.

Many wallets are made with standard size slots for credit cards and we heard some feedback that the Medicare cards were slightly larger and so people were having some trouble fitting it into those slots.

And so this card that will be mailed out to them is slightly smaller to match the size of a credit card. And you might notice from the sample that we also added some Spanish text to the standard printed text on there.

So, things like name will now appear in English and Spanish. All of those identifiers will be in bilingual languages.

So, we also will have those English and Spanish for the information on the back of the card and the information that goes on the card, the larger piece of

paper that surrounds the actual Medicare card when it is mailed to beneficiary. So, all of that sort of standard information will be printed in both English and Spanish.

We also removed gender and signature lines from the new card. We had some feedback that although those were used for certain things, they didn't necessarily need to appear on the card.

And so we have removed those to create some more space for some additional information and just some more white space to make, again, the pertinent information like the effective date and things like that stand out a little bit better.

And then the last thing I wanted to mention is that all of the cards including those for Puerto Rico will now be printed on white paper, similar to the current card. We did have a lot of – a lot of information that we gathered around the possibility of doing plastic cards, about possibility of doing smart cards that we investigated.

All of those things as it turn out were very much cost prohibitive not only on the CMS side but also on what they would require on the provider side to be able to accept smart cards in particular.

And so these cards will also be printed on white paper and we are stopping at the point of the new card to providing beneficiaries in Puerto Rico with plastic card as they have been provided for those last many years. So Puerto Rico cards will look identical to the rest of people with Medicare.

In terms of mailing these out, I mentioned that we have statutory deadline of April of 2019. We expect to start mailing new cards to beneficiaries in April of 2018 and do them on a flow basis over that approximately 12 months period.

Newly eligible beneficiaries will get a card with the unique number after April of 2018 or staring in April of 2018 regardless of where they live and we'll go through a couple of scenarios of how that will work in a minute.

We do expect for – as I said this to be on a flow basis. We're mailing about 60 million cards, give or take, and so it's next to impossible to drop those into the mail system all at the same time. So we're trying to make sure that people understand that they will get a card at some point during that mailing period but not necessarily soon after we start the mailing.

The mailing will include both the new Medicare card on a larger card with instructions as well as a letter that tells them why they're getting a new card and what we want them to do with it.

And we will be distributing those cards or mailing those cards by geographic location. We are not sharing a particular detail schedule at this point in time but we do expect to share information about who will get their cards when closer to the actual mailing being executed.

The other information that is important to know here is that we're asking beneficiaries to start using their card as soon as they get it. There's no reason to wait, there's no effective date.

As soon as they receive the new card in the mail, we want them to destroy their existing Medicare card and start using the new one. However, we know that there's a need for some transition time, especially on the providers with the various systems that use these numbers.

And so, CMS has built a transition period through the end of December of 2019 which all of our systems will accept either the SSN-based number or the HICN, or the new alphanumeric numbers that are coming out on the new card. And then starting out on January 1st of 2020, we will only accept the new card and the new numbers.

And then the last thing here around the mailing, the Railroad Retirement Board will be mailing new cards as well to all of its beneficiaries. They will take care of that mailing rather than CMS. The cards will look very similar to our new card design.

They will have language on the card, on the front of the card to note that it's a Railroad Retirement Board beneficiary. And they will also swap out the HHS

logo for the Railroad Retirement Board logo but otherwise they'll look exactly the same as the rest of the Medicare card.

So a couple of scenarios on how this will work for new beneficiaries who are becoming eligible for Medicare during this period of time when we are conducting the mailings of the new replacement card.

So in this first scenario, Mrs. Jones becomes entitled for Medicare in 2018. She is already receiving Social Security, so she's going to be automatically enrolled in Medicare.

Remember in March of 2018, our mailings haven't started yet and Mrs. Jones will actually get her Initial Enrollment Period package a few months earlier before she becomes eligible.

So, she gets the Medicare card with her IEP package in January of 2018. When she gets that IEP package because it's before we started issuing new cards, she will get a current IEP package with a current Medicare card, with the HICN or Social Security-based number on it.

And then, she will wait until it's time in the mailing period for her geographic area where she lives to be on the schedule to receive their new cards.

In this particular scenario, that's in May for the place where she lives and so she will get her IEP package in January with an old card, with a HICN-based on her SSN. And then, she will get another package a few months later in May as part of our regular mailing that will give her a new card with a new number and that letter that tells her why she's getting a new card.

In the second scenario, Mr. Smith becomes entitled a little bit later in the year. So, he is aging into the program in August of 2018. He will get his Initial Enrollment Period package in May of 2018.

And even though his geographic area isn't scheduled to get replacement cards until later in the summer, he will get in May an IEP package with his new card, new design, new number.

That will be his only Medicare card. He will never get a card with his SSN-based number on it because he's enrolling or becoming eligible and getting a card after that April 2018 date. So, the first package that he gets with his IEP and all of his initial enrollment period information will have a new design card with a new number. He will not get another one.

So when the rest of his neighbors are getting their replacement cards and this scenario in August of 2018, Mr. Smith will have an empty mailbox and he will not get another duplicate Medicare card when they mail it to him. It will be suppressed from that mailing to its geographic area.

And then in the last scenario, Ms. Green signs up for Part B using a special enrollment period that she's eligible for in March of 2018. She will get the current Medicare card with the SSN-based number because she's getting them in March of 2018.

And then, she will get another card when the rest of her neighbors get their Medicare card replacements in September of 2018 and she will get a new Medicare card then.

So basically if people are getting the Medicare card for the first time, either a replacement or their initial card after we started mailing, we will only – starting in April of 2018, we will only be issuing the new Medicare card design with the new numbers.

Just a couple of things about replacement cards, this was something that we currently do a lot of in the Medicare program. People lose their cards all the time, they asked for replacement cards.

A lot of them go through the laundry and become unreadable. We're asking that to be ready for the new card mailing, the replacement cards that we are mailing. The people with Medicare should make sure that Social Security has their current mailing address on file now. Not to wait until we start mailing cards.

If they moved recently, if they haven't been getting things like their Medicare handbook or mailings from Social Security, they need to check to make sure that address is current and it's up-to-date and is accurate.

So, that's one of our key messages for this fall, especially during open enrollment is if they had a change of address recently that they need to remember to update that with Social Security, so that they get their new cards when we start mailing.

We also will continue those replacement card operations. So if people, again lose their card or their card becomes damage now, we will continue to do replacement cards without delay, without a break in that operation up through March of – at the end of March of 2018.

They will get a replacement card that is the current card, the SSN-based number starting on April 1st, if they request a replacement card. Even if it's not time for their geographic area to be mailed cards yet, the replacement card will be the new card with the new number.

And then, an important aspect of this change also is that we do believe that people will have the ability to request a new number if there's evidence that there has been a security breach or somehow their number has been compromised, if they had been the victims of identity theft.

They will be able to get a new Medicare number which has been difficult in the past since it was based on their Social Security Number or someone else's Social Security Number.

The next piece that I wanted to talk about is just to share some recent findings throughout this project, made it a priority to be often out in the field with beneficiaries and talking with them about different aspects, getting some feedback and really allowing that feedback to drive our messaging and talking – and how we talk to people about this change and what's coming and the kinds of things that we need to focus on in terms of messaging and outreach.

So most recently, we fielded a – online and telephone survey with a little more than 1,000 Medicare beneficiaries, starting towards the end of July and running through the beginning of August.

So for a couple of weeks, we were really interested in getting a baseline of their awareness of the fact that new Medicare cards are coming, of their expectations for this card.

Those types of things to sort of figure out what it was that we had in front of us – or how daunting of a task the outreach and education around this is going to be.

And we wanted to do that before we started a lot of the early outreach, the products and the Medicare handbook mailing that I will talk about in a minute or two. So this was really we haven't really done anything active in terms of outreach and messaging to beneficiaries and we want to get a sense of how much they knew about new cards.

It turns out, again not surprisingly, they don't know a whole lot. There is extremely low awareness that they would be getting new Medicare card. Only 11 percent said that they had seen or heard or read something about Medicare cards changing at this point in time.

When they were told that they would getting new Medicare cards as part of the survey, the response to this was very positive and we've seen this in other research as well.

About 88 percent said that they thought that this was a good change. About the same number said they support removing their Social Security Number from Medicare card. They saw that as a good thing.

They agreed that a new Medicare number that wasn't based on their SSN would be more secure and protect them. And a majority of 79 percent also agreed that that they thought a new Medicare number would help protect them from identity theft.

When we ask them if they had any concerns about this change, about 75 percent said they couldn't think of anything that concerned them. So then when we push them a little bit further which we tend to do in these studies, we don't take no for an answer. We asked them about some very specific potential concerns are you concerned about how much this will cost for example.

The things that came to the top there as their greatest concerns, when we probed on them specifically, where about 61 percent said, yes the cost of replacing all these cards might be concerning to me.

About 42 percent said, they might have some trouble finding their Medicare number if they lost it, whereas now they can probably figure it out since – based on the number that they know, those types of things. But overall, again, the concerns were really minimal and they had to be kind of prodded into that.

What all these means for us is that we have some really important communication opportunity. So, there's an awareness gap here that needs to be filled. We have messaging that can fill that gap, can make people aware of this.

We need to build on their existing expectations around this type of an event. Even though very few of them are aware, there is – I'm sorry, even among those, the very few who are aware of this, they still couldn't speak a lot to the timing.

So, they might have heard that we got new Medicare – we're getting new Medicare cards but they're not sure when that's happening. We can build on the fact that they see this as a positive change and we need to reinforce with them what to do when the cards come in the mail.

The next couple of slides, I'm going to go through quickly. We have just an overall guide for how we're handling outreach over the next few months until the card mailing start.

This is really around open enrollment time and so we want the card – the new card messaging to be a supplemental message to existing open enrollment

outreach that we would be doing around, looking at your plans and comparing, and oh by the way, do you know that you'll get a new card next year.

We'll start to ramp that up in January after open enrollment sort of dies down and then of course we'll do some more targeted messaging when the card start mailing. We do have some outreach and education materials now available to the public.

If you've seen the new Medicare, a new handbook that is mailing to beneficiaries now, the inside front cover is sort of a full-page ad about the new Medicare card.

So if you open your handbook, it's hard to miss it. We also have some messaging built in to our Medicare calendar which was a popular product this year. We sold out – of our warehouse sold out, meaning they're free, so I'm not sure I can really call that sold out. They're gone.

From the warehouse, it's a little more than a 100,000 copies, so we're doing a reprint of that in early October and making those available. The March 2018 page has a reminder that new cards are coming and then we have a standalone one page flyer of that inside front cover of handbook available for outreach event as well.

A couple of – shows on the next couple slides of what that inside front cover and the standalone flyer looks like. We're also doing some job aids for partners as well as some information to be available for providers to put in their offices, tear-off pads for their front desk, some posters to put in their offices.

Again, just on the next slide you can see sort of a sample of what the tear-off pad and this will be a little like sort of 3 by 5 pad where they can take this and have the contact information for SSA if they need to update or address this.

We're also doing a lot of information about what providers can do to get ready. There is a letter that is going out now to providers, talking about the

provider look up tool that will be available and giving them instructions for how to get ready to be able to access that tool.

We're asking them to check with their billing vendors about system changes and make sure that those vendors are preparing for this change, so that they can accept the new Medicare numbers and ensure claims processing goes smooth as they transition to the new numbers.

We will be sharing with them, as I said, the posters and the tear-off pads and asking that they order those and put those in their offices and waiting room.

And then we're releasing information through the Medicare Learning Network as well, encouraging them to look on our dedicated web pages for this project and the URL is there on the slide.

We made a shorter URL to make this easy for people to find and bookmark because we'll be putting a lot of information including this slide deck, posting on there for people to be able to provide outreach and get their hands on materials and the latest information that we have available.

This is a screenshot of the current homepage for that website. This is what you'll see as you come up. And then just quickly a couple of things about our Guard Your Card campaign, this is running now.

It started toward the end of August. We have a couple of objectives to get people's awareness of about protecting themselves against fraud, about spotting fraud in the Medicare program, protecting their card and especially protecting their number.

These messages won't change with the new card. We still want people to treat their Medicare card as if it were a credit card and protect that number in the same way that they do today. We have some paid and earned in social media activities going on around this campaign through earlier this week, those ads ended.

You probably saw them if you watch channels like the Lifetime or a Hallmark channels or you're watching some Wheel of Fortune or Family Feud or

evening news, that's sort of where we bought ad space. These are the ads that end with "Stay) sharp people!" and now we're shifting into some more earned and social media through the end of the open enrollment period.

These are sort of the messages that we've used. These are not new in terms of fraud campaign messages. The new addition to this is the mention of the new Medicare cards without Social Security Numbers being mailed next year, kind of added to these overall messaging structures of fraud prevention.

And then I just included here another link to the new card website and the information on cms.gov as well as our corporate mailbox is available for any questions or comments that you have about the new Medicare card project.

Dina Payne: Thank you so much Erin for this important information. Before we take questions from the audience, I just have one additional question for you. Will people in Medicare Advantage Plan also receive a new Medicare card?

Erin Pressley: That's a great question Dina and we had a lot of discussion about folks in new Medicare, sorry, folks in Medicare Advantage Plans and how to message them as well. So, the quick answer is all people with Medicare including those that are currently enrolled in Medicare Advantage or Part B plan will get this new Medicare card.

They're still part of the Medicare program, even if they've enrolled in a Medicare Advantage Plan. And so even though they will still use their Medicare Advantage Plan card, they will get a new Medicare card.

And many times hospitals and other providers asked them to bring both, and – for reporting purposes, they have to show their original Medicare card as well. So, we are mailing to all of them.

We're working with the Part C plans and Part D plans to make sure they are amplifying our messaging to their members so that their members are not destroying the wrong card. That they have the Medicare Advantage card separately and that they know what to do when they get their new Medicare card.

Dina Payne: Thank you. That's very helpful to know. Now, I like to open up the floor for questions from our audience.

Operator: Certainly and again if you would like to ask a question, press star then the number one on your telephone keypad.

Again that's star one on your telephone keypad. Your first question comes from the line of Kevin Robertson with North Carolina SMP. Your line is open.

Kevin Robertson: Thank you. I'm calling to see mainly do we know what the envelope will look like, this new card will be coming in. I know with the SHIP program, an SMP program, we're trying to make the beneficiaries aware about the new project, but we would like also to be able to let them know what to look for.

Erin Pressley: That's a great question. Kevin that's a great question. Thank you. We do know what the new -- what the envelopes will look like. I don't want to give you misinformation. We can certainly share that in future briefings as well and get photos of that.

It will be a fairly nondescript envelope so we've again gone back and forth about whether it should be a colored envelope, whether it should be emblazoned with your new Medicare card is inside, sort of balancing the need to make sure beneficiaries pay attention to the envelope with also not wanting to make it easy for people to look at out of their mailbox. So it is a pretty standard sort of plain white envelope with the window address. So …

Kevin Robertson: Thank you.

Erin Pressley: similar to the envelopes that are used to mail Medicare cards replacement cards now.

Kevin Robertson: Thank you.

Erin Pressley: You're welcome.

Operator: Your next question comes from the line of Jason Echols with AgeOptions. Your line is open.

Jason Echols: Hi Erin. Thank you for doing this and I should say I'm from the Illinois SMP too so like Kevin and I just wanted to ask can you share any details about how you reach out to people who are non-English, non-Spanish speakers.

It's great that it's bilingual, but for people who don't speak English or Spanish or reading this in Spanish, what type of outreach are you all planning for.

Erin Pressley: Sure. That's a great question. We are in discussions right now about the details of the outreach in other languages beyond English and Spanish. We do know that our regional offices or CMS has 10 regional offices every year, get some small amount of funding to do localized outreach on a number of topics.

They are using all of that funding allocation in 2018 to talk about this new Medicare card and so we're working closely with them to develop a plan for which languages and which products we'll be able to translate into other languages and what languages those will be.

So you'll -- you can expect to hear more about that, but we are absolutely talking about it and we'll have a plan for outreach and more targeted information in certain areas of the country for those folks who have limited English proficiency.

Jason Echols: Thank you.

Dina Payne: Thank you very much. In the interest of time, we are going to move forward to our next presenter, but we'd like to invite all participants who have additional questions related to the new Medicare card to please send those questions to the partnership mailbox. And we will ensure that they -- that Erin receives them and that we will forward additional information and responses to your questions to you directly. Thank you. And last, but certainly not the least is now my pleasure to introduce Jason Green.

Jason Green: Hello. Thank you for inviting me on to the call. I wanted to do a presentation a little different from what I done in the past.

I work for the ALJ hearing level here at the Office of Medicare Hearings and Appeals so I've always focused on the ALJ level, but I wanted to provide a presentation focused on beneficiaries and the entirety of the appeals process for benefit entitlement and claim appeals.

So that's what my presentation is focused on and the slide deck is very detailed and offers a lot of little tips as well as the guidelines for how and when to request different appeal levels. So I'm not going to get in to the details. I'm going to try and just go over on a high level what's presented in the -- in the slide deck.

So just want to state upfront that this is my slide deck. I have already discovered a mistake that I'll highlight, but it is not authoritative and it's not exhaustive of a party's rights and responsibilities in pursuing an appeal.

Also we tend to focus on the A/B program, the fee-for-service program, but when we're talking about beneficiaries, the Part C Medicare Advantage and Part D prescription drug programs become a lot more relevant.

They pursue most of the appeals under those two programs versus Part A and B where appeals are generally pursued by the provider or supplier. So I try to really highlight the Part C and Part D programs.

Now, in Slide 4, I have the basic rundown of the entire process beginning with the first step, which is really a determination is made by a contractor or a plan and that is to deny a service, to deny an item whether it's pre-service or after the item or service has been furnished or for entitlement issues to deny entitlement to the program or to assess late enrollment penalty under Part B or an income-related monthly adjustment amount under Part B or Part D.

So that initial determination is made and then if a beneficiary is unsatisfied with that, which is in all likelihood if it's denied or entitlement is not given, they can pursue administrative appeals and there's a number of levels in the process here at HHS. There can be two or three levels of administrative appeal and then judicial review can be sought in U.S. district court.

Now in Slide 5 through 9, I detail the many different actions that are those initial determinations. Under Part A and B, they are called initial determinations. Under Part C, they are called organization determinations. Under Part D, they are called coverage determinations.

Basically, it is an item, service or drug is not being furnished to the beneficiary if it's a benefit appeal or the Social Security Administration is saying someone isn't eligible or entitled to the Medicare program where they have assessed a late enrollment penalty under Part B or the aforementioned income-related premium adjustment, also called IRMAA.

So you can see the many different things that come up. The one item I wanted to highlight on Slide 6 are that if there is a provider that's terminating coverage, the beneficiary can appeal that termination and usually those reviews are conducted by a QIO, which is a qualified independent organization and those are very fast-paced appeals through the QIO.

So you'll want to help your beneficiaries by making sure they follow those guidelines and the timelines for appealing those terminations so they can preserve their rights to coverage while appeals are pending.

Now in Slide 10, I have an overview of the administrative appeals process and I highlighted that there's redeterminations or reconsiderations.

Generally those are conducted by the same entity that conducted the initial determination and then sometimes you'll have an independent reconsideration so this is a CMS contractor coming in, different from the initial contractor to do an independent reconsideration.

Keep in mind that the process varies depending on what's been appealed. For example Social Security Administration determinations do not go through an independent contractor. QIO reconsiderations generally (even either).

Now once the contractor or CMS and SSA levels of appeal are exhausted, the process comes together here at OMHA for an ALJ hearing to unified process and then there's another level of administrative appeal with the Medicare

Appeals Council and then obviously judicial review comes after that and I try to provide a little map for the process as we go through this.

Now on Slide 11, I wanted to highlight timeframes through the process. You have different timeframes from different things. The time to request an appeal, you need to pay attention to that as beneficiaries do.

Make sure they get request in on time or they will have to establish good (cause for like) request. There's time to get the decision so between the request and when they're going to get a decision.

Some of those timeframes are established by statute of regulation and for certain appeals specifically Part A and Part B quick reconsiderations, there is an opportunity to escalate an appeal if decisions aren't made in a timely manner and that will move the case to the next level of appeal.

On Slide 12, I provided a few tips. People should be realistic about what they're appealing. Medicare is a defined benefit program so and you know adjudicated (you have) to follow the law so they can't be asked to approve an item or service that is not permitted under the program.

The other items to highlight for folks is you know to explain why they think an item or service should be covered and in doing so, they need to address why it was denied at the lower level so that really helps the adjudicators as things move through the process to focus on the reason for denial and why the appellant things and item or service should be covered.

The other item to highlight is to make sure beneficiaries are including copies of documentation. We have had instances where folks and does the originals and don't maintain a copy for themselves so that's really important to highlight for them, but they need to keep the original version on hand and then just send a copy to contractors or us.

And the last point on there is really important. Always follow the appeal instructions. As you -- if you (peruse) this, you'll see there is lots of different (past) things can take.

It's really important to follow the appeal instructions to make sure folks are getting their request to the right entity and that not only helps to make sure their appeals are processed as quickly possible, but there and it also prevents any mistakes that can happen along the way where they exhaust their appeal rights and don't have timely request.

So on Slide 13, I will begin discussing the redetermination, reconsideration, appeal step where things are visited by the same contractor that adjudicated the initial determination and your time to request will vary based on what's being appealed and who can request the appeal will (vary that) as well.

Now on Slide 14, I have some information on when expedited reviews are available and when folks can expect a decision. On Slide 15, I discussed the independent reconsideration, again how long they had to request things, which vary; who can request things, which vary and then on Slide 16, expedited reviews and expectations for receiving a decision.

On Slide 17, we begin with the ALJ hearing level and this is where the processes unify a bit. So one thing that I want to highlight here is the time to request is incorrect. It is basically 60 days from receipt of a reconsideration.

It says here that Part C reconsiderations do not require a request for hearing. That's not true. The beneficiary or in that instance an enrollee does have to affirmatively file a request for hearing. It just that it goes to the independent review entity. Again, all of this would be explained in the appeal instructions.

Now for who can file a request at the ALJ hearing level, things do change a bit for Part C and Part D enrollees and that is important to highlight because we do have some issues with this.

At lower levels, a physician under Part C or a prescriber under Part D can file on behalf of an enrollee. They aren't appointed as a representative. They just file on behalf of their patient.

At the ALJ hearing level and the council level above us, they have to be appointed representatives. So if a prescriber files a request for ALJ hearing for the Part D enrollee, we're going to reject that if they aren't an appointed

representative and that is under regulation. We are obliged to follow that. So if you have beneficiaries who are appealing, just make sure that they are appointing their physician as a representative.

Expedited reviews at the ALJ level are fairly limited. We just have Part D expedited reviews when someone had not obtained a drug and the regular timeframe would post serious jeopardy to life or health or their ability to regain maximum function.

Now on Slide 18, I wanted to highlight that at the ALJ level we have a number of programs out there to assist beneficiaries and enrollees. We have a special mail stop to send request for hearing. Now if the appeal instructions data send it to someone else, make sure they send it to someone else and that someone else will get it to us.

So Social Security will take in appeals of the -- their reconsiderations, package them up and then send them to us, but if they're told to directly file with OMHA, make sure they send that request for hearing to the address I have on this Slide 18. It's also in the appeal instructions that they'll receive with their reconsideration.

Now Part D, again expedited hearings are unique. They can file request orally and they can also fax request. Again, all of this would be in the appeal instructions.

On Slide 19, I want to highlight that we do have a beneficiary enrollee appeal prioritization program here at OMHA.

We do have a backlog of appeals, which primary affects provider, suppliers and Medicaid state agencies who appeal to us, but for beneficiary and enrollees, their appeals are prioritized, which means they get assigned as soon as we can get them in our system and then once they're with the judge, they are put on top of all the work that they have so they are prioritized throughout the appeals process.

We've also established the dedicated helpline for beneficiaries. I provided that on Slide 19 as well as the helpline for other appellants. We would ask

other appellants to make sure they use the 1-855 national number, not the beneficiary line so we can preserve that special line just for the beneficiaries and the unique issues that they have and present.

Now I did want to highlight on Slide 20 a few things. As your advising beneficiaries are helping them (align), when they are not the appellant, they are going to receive notices. Generally, it's just to keep them informed about what might be happening with an appeal of services that were furnished to them and they aren't involved, they aren't financially responsible, but they will get notices so I detailed some of what they might receive.

There are case -- I'm sorry at OMHA, we generally will not send them a notice of hearing unless they're going to be possibly financially responsible where the ALJ for some reason really thinks their testimony might be especially helpful.

Now in Slide 21 and 22, I just provided sort of a walkthrough of the ALJ hearing process. Just we go through a procedural screening, a case record is reviewed and then a hearing gets scheduled and then a hearing is conducted and beneficiaries should be aware that CMS and its contractors or a Medicare Advantage Organization or a Part D plan sponsor might be at the hearing as well.

And the ALJ can ask questions of anyone and a beneficiary who is there as a party also can ask questions of folks, but the judge really controls that process and is -- and charge and directs the hearing.

And then after a hearing is conducted, the ALJ is going to issue decision instructions to his or her attorney advisor and then a decision is drafted that the judge will review and eventually sign off on once he or she approves of everything and then that will be (shared) to all parties involved.

Now Slide 23, I wanted to highlight when beneficiaries can expect a decision. Again, we had delays for other appellants, but the beneficiary appeals are prioritized and we do expect our judges and other adjudicators to issue decisions within 10 days for a Part D enrollee expedited appeal, 90 days for a

standard beneficiary or enrollee appeal or 180 days if a beneficiary escalated a quick reconsideration.

And I do have a few details about the backlog here at OMHA on that slide as well. Obviously our primary measures to assist beneficiaries is prioritizing their appeals. Most of the other measures to assist provider, suppliers and Medicaid agencies are focused on their appeals and not applicable to the beneficiary appeals.

Now on Slide 24, if a beneficiary is unhappy with the ALJ's decision or under recent rules, attorney adjudicators can issue decisions when no hearing is held. They can appeal the decision to the Medicare Appeals Council.

Now that's on the record review and a request can be submitted for that review within 60 days after receiving an ALJ or attorney adjudicator decision.

Again pay attention to who can file a request because in Part C and Part D like at our level, the physician or a prescriber can't file on behalf of. They have to be an appointed representative. Again expedited reviews are available for Part D appeals.

And then on Slide 25, we provide some more information on requesting council review and then they do have an online filing system so you can request electronically at the website provided there and then file oral request for expedited hearings under Part D as well.

On Slide 13, they did ask that I provide some information for their beneficiary enrollee appeal prioritization program and then they do have an assistance line if someone has questions.

On Slide 27, I wanted to highlight something for beneficiaries. Even if they get a favorable decision at the ALJ hearing level, CMS or a contractor or a Medicare Advantage Organization can ask the council to review that favorable decision.

So sometimes they will see that a referral is made by CMS or a contractor or an appeal is made by a Medicare Advantage Organization and that will ask the council to take a look at the decision and review that.

So usually that will happen when there is what they believe is a clear error of law and the appellant in this instance the beneficiary will be given a period of time to object to that referral or opine on why they think the decision was correct.

On Slide 28, I just detailed the different actions that might happen at the council level. So a council action could adapt, modify or reverse an ALJ or attorney adjudicator's decision, could (vacate) the decision and (remand) it back. They could also deny the request for review or the own motion referral.

We can also expect the decision on the same timeline that are here at the OMHA level 10 days for expedited Part D appeals, 90 days for standard appeals and 180 days for escalations from the ALJ hearing level.

On Slide 29, I detailed the judicial review level a bit. This one has an increased amount in controversy and the regular filing cost for U.S. district court apply so it is something that we don't see a lot of with beneficiary appeals, but it is available.

Time to file and who can file is all detailed in the rules and in appeal regs that are sent with council actions and what is filed is actually a civil complaint against the secretary.

Now that's the quick version of my slide deck. I also have some supplemental slides that detail how you can look up the status of an appeal here at OMHA, contacts here at OMHA as well as the last slide, which is sort of my personal cheat sheet of the different appeals that come through us here at OMHA for Part A/B, Part C and Part D.

As you will see if you look at Slide 35 that is a little complex at the lower levels, but then comes together here at the ALJ hearing level. So that is the quickest I can get through this and I hope that was informative. The slide deck has a lot more detail and I will turn it back over.

Dina Payne: Thank you so much Jason. Really appreciate your willingness to present this information and would like to -- before we wrap up today, I just have one additional question for you.

Based on the information that you shared, it seems like there are a lot of different paths and appeals to take, can you provide just one rule of thumb to help folks navigate the process?

Jason Green: In terms of navigation, following appeal instructions is really the key. Again, each level is going to have its own appeal instructions for the beneficiary appeal to this other contractor or send it back to us or send it to OMHA.

So they really need to focus on the instructions and then if there are special instructions because they're a beneficiary, again follow those and that will -- that will really help keep their appeal moving.

Again if they are told to directly appeal to OMHA, sending it to our beneficiary mail stop is going to put it at the top with everything we get and we get a lot so it's really important that it'd be at the top so the appeal is moved as quickly as possible.

Dina Payne: That's good information to highlight. Thank you so much.

Again in the interest of time, we would like to invite you to e-mail us at CMS Partnership mailbox. If you have any additional questions for Jason or any of our other presenters and the e-mail address for the partnership mailbox is partnership@cms.hhs.gov.

Again, please feel free to e-mail your questions and we will follow up with the presenters if necessary and ensure that your questions or request for additional information are resolved.

Thank you again for joining us all today. This concludes our presentation. We appreciate you taking time out of your schedules to be with us and we hope that the information that's been shared with you today has been helpful.

We are always interested in hearing more about the topics that you, the audience would like to learn more about doing future NMEP meetings and we encourage you to e-mail your suggestions or again any additional questions that you may have about today's presentation to our partnership mailbox and I'll repeat that address again. It's partnership@cms.hhs.gov.

And as a reminder if you would like to revisit today's meeting, the audio recording and the presentation materials, all of the slides from today's presenters will be posted to our NMEP website in about one week from today and once the materials were posted, we will send you an e-mail with the link to the website so that you may view those materials at your leisure.

So again thank you today for joining us. We appreciate your participation and we look forward to continuing our partnership with you. Have a great day everyone.

Operator: This concludes today's conference call. You may now disconnect. Presenters, please remain on the line.

End