CMS All Tribes Call Webinar
CMS Task C
Medicare Part D Open Enrollment, Program, and Plan Finder Updates
November 2, 2012

Kitty: Good afternoon and welcome to today's All Tribes Call sponsored by the Tribal Affairs Group within CMS. I am Kitty Marks, Director of the Tribal Affairs Group, and joining me on today's call is Captain Pam Schweitzer from the Indian Health Service and Jay Dobbs from the Office of Communications here at CMS. Also joining us on today's call is Kay Poker-Zewa from the Center for Drugs and Health Plan to answer any questions regarding reassignments and low income subsidies or other general Part D questions. The All Tribes Calls provide an opportunity for CMS to solicit input from IHS, tribal, and urban programs on implementation of or changes to CMS, legislative, and regulatory provisions impacting American Indians and Alaska Native beneficiaries and the operation of the Indian health program delivery system. The purpose of today's call is to provide an opportunity for tribes to learn about Medicare Part D updates specific to IHS and tribal pharmacy and how to use the Medicare Plan Finder to enroll patients in Part D for 2013. After today's call CMS, working with our contractor KAI, will make the PowerPoint presentations available by posting them on the CMS American Indian/Alaska Native website page that can be located at www.CMS.gov, then you can click on the Outreach and Education link and then click on American Indian/Alaska Native. At this time, I'd like to turn the program over to Captain Pam Schweitzer who will lead the webinar on Medicare Part D's open enrollment and program updates and then following Pam's presentation, Jay Dobbs will present on the Medicare Plan Finder updates. Pam, go ahead.

Pam: Okay. Thank you very much Kitty. And, I want to thank you a lot for having me here today and especially for all the support that you have given Indian health tribes and urban programs.

Kitty: You're welcome.

Pam: Okay, besides providing an update on Medicare Part D for 2013, I also just was going to provide some general information and helpful reminders including an update on the coverage gap, fraud, waste, and abuse training and processing claims. The handouts and resources for everything that I'm talking about is also available on the point-of-sale FTP site and it's in a folder called Medicare Part D 2013 and at the end of this presentation I will share that link so you can also refer to that. Okay and you probably have already seen this, but open enrollment started on October 15th and it goes through December 7th and if you don't already have it there's a really good resource that everyone every year should download and have available and it's called 'Medicare and You 2013' handbook. I also put a copy of it on the point-of-sale FTP site and then also there's a resources that I put on there, the CMS Social Security and Plan Mailing, which I'm going to show you here in just a second. So anyway, this is what you should download here. It's a great resource to have on hand. It has a lot of really useful information and explains it very clearly just everything about the prescription drug plan plus other Medicare information. And the links are on the slide there, but as I said it's on the Point of Sale FTP site. And then I thought I should mention, if you hadn't seen it on page 94, if you go there, there is a little section on Indian Health Service and you know it's specifically for us, and I thought you would just like to see that especially if you are a patient benefit coordinator and it says, 'Joining a Medicare drug plan may help you...help your Indian health facility, because a drug plan pays for the Indian health facility for the cost of your prescription. Talk to your local Indian health benefits coordinator who can help you choose the plan that meets your needs and tells you how Medicare works.' So anyway I thought you would like to know that they included that in there. And then this handout here is also on the Point of Sale FTP site and those of you that are patient

benefit coordinators especially would want to know this, it has all the guide to consumer mailings from CMS for 2012 and 2013 and it helps explain the mailings that the beneficiaries are receiving. As you can see it is color-coded to match the color of the notice. So if the patient receives a blue notice you know it is a reassignment notice from CMS. And then, I also wanted to just talk a little bit about the coverage gap. The coverage gap most likely is not...will apply to patients that do not qualify for low-income subsidy; in other words the patients that are not dual eligible patients. The coverage gap, it's a temporary limit on what the drug plan will cover for drugs. This year the yearly deductible is $325. Once the patient and the plan pay a combined amount of $2,970 the patient is then in the coverage gap. If the patient spends up to $4,750 out of pocket for the year than the coverage gap ends. So that's how the coverage gap works. Since last year those Indian beneficiaries who have Medicare Part D drug coverage that reached the coverage gap or the donut hole, they can come to an ITU facility to help them get through that. The spending at the ITU facility will count towards the annual out of pocket threshold. So that's important information to get to our beneficiaries or the Indian beneficiaries that do not qualify for LIS, that are not dual eligible. And just as a reminder, not everyone enters the coverage gap. Dual eligible patients or those receiving full low income subsidy do not reach the coverage gap. And then, what I did here for those that do reach the coverage gap, as you can see this has been happening over the past several years and it's slowly closing. You will notice for 2013 those that enter the coverage gap are going to pay 47% at the cost of the brand-name drugs while they're in that coverage gap time period, the donut hole, and then 86% of the plan cost will cover generic Part D drugs and then once they reach the catastrophic coverage, the coverage gap ends. And then as you can see down by 2020 the coverage gap will be closed and then once again you're going to... You're encouraged... You should encourage those beneficiaries that will reach the

coverage gap to use an ITU facility to help them out with their out of pocket drug costs. Okay, I wanted to talk a little bit about the critical coverage notice and a lot of this information is really for people that are new in the patient benefit coordinator role. The credible coverage is other coverage that is at least as good as the Medicare drug benefits. A penalty would apply if the beneficiary did not enroll in a Part D plan when they become eligible or if there is a period of 63 days or more in a row when they do not have Part D or any other credible coverage. Indian Health Service is considered a credible coverage. So a few years ago we changed the process for credible coverage notices. Rather than mailing credible coverage letters to all eligible Part D beneficiaries, that's Indian beneficiaries, facilities now only need to provide a credible coverage notice to new and existing members who may be eligible for Part D services. Credible coverage notices are to be prominently displayed in a patient waiting areas and if needed to avoid a penalty, the sites need to have a process in place to provide the patient a personalized letter on facility letterhead. A copy of this policy and the letter are located on the Point of Sale FTP site. I did modify it just slightly or actually we did modify it just slightly to make it more current. I think last year the letter said... Last year we started this program. It's changed so that it's more current. It will stay current for... You can use that every year. So there's actually a sample letter. You can pull down and you just have to fill in the information and put it on letterhead to use, but we wanted to make sure everybody was aware of this, because part of our responsibility in Indian Health is to make sure that we all know this information so our patients don't get a penalty if they didn't enroll right away. Fraud, waste, and abuse training. Okay, I wanted to remind everybody if you have not already done so that all the staff involved in enrolling and billing Medicare Part D needs a complete the fraud, waste, and abuse training. There's several plans and PBM's, patient, uh Pharmacy Benefit Management companies that have training

available that you can use. It's for free. There's also a training on a Point of Sale list that you can use. And on the last page there is a place where you can enter the name and print it off so you can keep it on file. This training needs to be completed every year and you will be audited by the plans. They are now auditing. They are asking for proof that everybody has completed the training and that is something you're going to have to provide back to them. So it's real important to have...you have a process in place and that you're actually documenting it that you're having the training and that the individuals are being trained. For tribal sites, you will also want to complete and return the attestations. For Indian Health Service sites, we are completing the attestations at the national level as we receive the requests. I know that we are really good at checking the OID Exclusion List when we're hiring new employees, but another part of this is that we always need to check once a year thereafter. So for all of our employees there's a website that you go to and I have that all on the Point of Sale FTP site that you'll need to go in there and to check all of your employees. It doesn't take very long. You just put everybody's name in and then you print that out and you document that you've checked it once a year. And some of the plans are recommending that we have a local policy and procedures for addressing fraud, waste, and abuse and on the Point of Sale FTP site we've included some sample policies and procedures that you may want to use and they were provided to us by some of the tribes and we are thankful for that. Okay, so I wanted to show you this. This year you may have already noticed that there's a few name changes for some of the Pharmacy Benefit Management companies, some of the companies that are processing claims and I included them on this slide. Um, Prescription Solutions now goes by OptumRx. SXE, which is System Excellence now goes by Catamaran as does Catalyst. And then Medco was bought by Express Scripts, so you're seeing some transition there right now. And then Benecard, which is another

company, is now going by RxAlly. And I mention these because it's really confusing to try to keep track of who's who and so I just put them on the slides just to help you out here. The other thing I just wanted to mention is that this year we have a few plan name changes that I wanted to make sure everyone was aware of. Two new names that we haven't seen before, one is SmartD Rx Saver Prescription Drug Plan and then the Reader's Digest is a new one and then for those of us that have been doing this since the beginning, Community Care Rx and Health Net Orange, they've been around since the beginning. They are now all merging into one which is the Silver Script Prescription Drug Plan. And I should mention on the last one that for those patients that are merging, they are all merging into the Silver Script Prescription Drug Plan that there's no action going to be required. They're just going to automatically transition them and they will be receiving notices of that and so you may see some of your beneficiaries, since we have so many in those plans, you may see them or they may tell you about, you know receiving a notice on that. And there's no action needed on their part. And then here is the list we put together. I just put a screen shot of one available if CMS is going to go ahead and post this afterward and then also its on the Point of Sale FTP site, and you'll see that up there in the folder, and I actually have it all broken out and there's two types of Prescription Drug Plans that I'm going to talk about. I'm specifically talking about the stand-alone Prescription Drug Plans. There's also another one. It's the Medicare Advantage Plan. This is like an HMO and that's where the beneficiary may have you know Part A, B, and D all through the same plan and a small percentage of our patients are seen...are in those plans. The prescription drug plan, the PDP, and the stand-alone prescription drug plan and this is the plan that the majority of our beneficiaries are enrolled in and this slide shows what CMS calls the landscape of stand-alone Prescription Drug Plans and it's really a summary of the plans that we have available and its divided up by

state and this is really helpful especially to patient benefit coordinators because the entire spreadsheet is... It kind of gives you a big landscape of the whole project. You'll notice there's different columns. There's one for state. There's one for the company name and for the plan name and the plan name is what we're kind of looking at there. And then there's another column for premium...for zero premium and full load subsidy. And that's like our dual...for our dual eligible, and I marked all of that in yellow so that you can see those easy. And then you can see the monthly premium. There's a column for that and the annual deductible and then there's a column... And you can see on this slide it's in blue. It's Contract ID. That's going to be real important for this year for those that are using RPMS. And at the final far right column, which you can't see on this slide, there's a star rating. I'll talk about that in a minute. So the plans that are most pertinent to us and that means those that are for the dual eligible patients, are marked in yellow. And if a patient... If a beneficiary qualifies for LIS and previously selected a prescription drug plan that is now has a premium - in other words, it's not one of the ones in the yellow section - you may want to assist them in enrolling in one of the zero premium plans and you can see that. So if you check later and you see that they are enrolled in a plan and it's going to have a premium and it's not one of the yellow ones and they do qualify for LIS you are going to want to help them switch. Otherwise, they will be charged a monthly premium. For those that use RPMS, you will be able to do a query in the eligibility report of the Point of Sale package and you'll be able to determine which plan the patient it is...is in. So when you run that you're going to see a field in there called a Contract ID and that's going to help you find out which plan they are in. If you notice this year, the deductible is $325 and what that means for us is we won't be receiving any reimbursement until that deductible is met. And just as a reminder, the coverage gap does not apply to the dual eligible patients. Okay, I wanted to talk a little bit about

the star ratings. As you know, like restaurants, hotels, and movies, they all have star ratings and last year there was a program started where CMS rates the Medicare Advantage and the Medicare Part D plans with stars and this makes it easier for the beneficiary to compare plans. Star ratings for the prescription drug plan are based on 19 independent criteria and it's focused on performance and quality data. And hopefully this can help beneficiaries select a plan, and I noticed this year there are some... which we didn't have that last year and I marked those in green on the spreadsheet. So when you get a copy of the spreadsheet, you'll see those are marked in green and we think this is really great news that they have this in place. It's very helpful. Okay, then I wanted to let you know we put another spreadsheet together and hopefully this is going to be helping... And this is really for folks that are using the RPMS and maybe even not RPMS, to help just sort of put in a nutshell all of the plans that we really need to kind of hone in on this year and usually there's a short list that we really, like the 8020 rule. We had most of our beneficiaries in those plans and so this list here, what it does, is it lists the most common plans that we're going to be using in Indian country and it's sorted by Contract ID. It will make them easier to find when you're running the eligibility transaction, and I also wanted to mention for the Indian Health Service facilities, we do have an agreement in place with all of these plans. There is one already in place. And we'll also just mention if you're a tribal facility and you have any difficulty or would like assistance in just making sure that you're getting the agreement, let us know. We'll try really hard to make sure we provide the plans with the information on tribes and IHS so that they can make sure they solicit you or send you a copy of these agreements so that you can enroll. And then for those that are using the RPMS, you use...The switch service that we use is called Indion and you're going to find that this website is going to be really helpful now to help...just to help get some of the information that you need to be able to process the

claims and it has information like the BIN and the PCN number and phone numbers for the different plans and processors. So I wanted just to show you that and also just to let you know if you want to... If you didn't have access to this, I put the link up here so you can go ahead and get your own access, but if you have any questions on how to do that, you can go ahead and e-mail somebody. E-mail I guess CMS or myself if you need any help getting it, but this link should help get you...be able to get you in. So if you use that already and you don't have access... We're finding a lot of people don't have access. We wanted to make sure we got the word out so that you can get it. It's a great resource. It also has other information if you need information on prescribers and information on just any data that you need to be able to submit the claims, the payer sheets, everything like that is in there, too. And then, I wanted to talk a little bit about some of the changes that are going to be made when you process claims this year and what we have not...what we're noticing. and I'll just say one of them that's not on this slide, is they are requiring now that every prescription that we submit needs to have a prescribers NPI. So in some cases what we have been sending is like the different number, not the pharmacy NPI or excuse me, not the prescriber NPI or we've been sending the facility DEA number or something like that. Those are going to be all rejected here real soon and some Plans have already started implementing this. So we want to just make sure that people are kind of looking at their provider list and making sure that that field is populated for all of their prescribers and make sure that they all have the NPI populated in their system. What we have found is most providers do have a NPI, it's just that it may not be in the system. So we wanted to make sure you did that. The other thing is that you're going to be noticing some other changes is that PBM's or the people processing the claims are going to reject claims when the drug may be harmful to the patient. So these are safety issues and one example is the high risk drugs in the

elderly. So what will happen is the prescribers are going to be encouraged to switch to alternative drugs, and you'll see notices coming out, because they are sending notices to all of us, all of the pharmacies, and I just wanted you to be aware that they are hard rejects. What that means is they are just going to reject it. It's not like a prior authorization where you have to get approval. It's a hard reject, meaning they are just going to deny it. Um, I also wanted to mention the pharmacy audit. We are required... Plans are required to audit the pharmacies and we have noticed a significant increase in the number of audits. So we wanted to remind everyone that we need to make sure that we have good processes in place, and I noted down here some of the areas where we're being audited and they include a prescriber ID, provider ID, prescriber ID that I mentioned already. Making sure we have signature logs. We know that a lot of the facilities now have electronic signature logs, which makes it very easy to find you know the proof that the patient received the medication. We are receiving audits on E-Prescribing. They are wanting copies of the prescription, the electronic prescription, and if anybody has any questions on how to provide that information back to the payers, I actually have put together...to put information together and instructions if people need it. I probably should post that up too if people have questions on how the format and how they should submit that in. And then there's focus on the high costs claims. So if there's... If you're an outlier in any area then you can probably expect to be audited, and they are checking to make sure people are completing the fraud, waste, and abuse training. I just also mentioned... I put down double billing there too because there are some audits on that that I've heard about. And then finally what I wanted to do was just put up the FTP site, put that link up that is avail... Um, that you can get some other resources and once again the folder is Medicare Part D 2013, so you should be able to find that and I also just put the link for *'Medicare and You 2013'* which if you wanted that too. So with

that I'm not sure if I'm going to take questions now or at the end, but otherwise I'll pass this on to Jay.

Kitty: Thank you Pam. Why don't we go ahead and have Jay present on the Medicare Plan Finder, and then we'll open it up for questions. Go ahead Jay.

Jay: Uh, thank you Kitty. Captain, thanks very much for that presentation. You touched on a couple of things that I will talk about in a couple of minutes and it's great sharing your time with you this afternoon everybody. Thanks for the invitation folks. This is just going to be a real short presentation about the actual updates and enhancements that we've made that we put in place for the annual election period, which of course as the Captain mentioned began the 15th. We are constantly in the process at Plan Finder, we're trying to both simplify the tools and add more information to it at the same time. I know that seems a little bit convoluted and sometimes it becomes convoluted, but we do try to add enhancements that our users hopefully will find enhances their experience. As the Captain mentioned... Um, Brandon, I'm sorry I'm not seeing where I should change the slides here. Maybe I haven't moved down enough. Oh, I see, never mind. Thank you. I see it. Always push full screen. Um, the Captain already touched on some of these important states, but I will just go ahead and repeat them. As folks were able to see and begin shopping on the Plan Finder the first of October. The important plan ratings information as the Captain mentioned earlier was up for and actually was revealed and started to be displayed on the Plan Finder to the eleventh and of course the important dates, the fifteenth through December the seventh, the annual election period. Here's one of the enhancements that we've only had in place fully since October 1, but we've had a version of it since our August, uh data and infrastructure refresh. For those of you who have used the Plan Finder before, you'll notice that when you were helping or you were choosing your own drugs, there were only a couple of

options for frequency and dosage. That is usually there was only either 30-day retail sales or 90-day mail order sales. Well, we've added more options than that because folks asked us to, because plans started to offer more than two options. So and as much as I admire my father for being a math teacher, he did not pass on that gene to me. So in the past, you had to do some math, because for example some retail pharmacies offer 90-day retail sales and so before this new enhancement, part of what you're looking at on the screen now was added, you had to add 90 days into the number of pills that you wanted to take over three months. Sometimes that became a little complicated. With the new screens that we have in place, the new options that we have, you can actually pick the option. Let's say, three months at retail or one month at mail-order and if those... If the plans that you shop actually have those options because it is up to the plan to offer those options than very accurate pricing will be available to you. If the plan does not offer the option that you chose then you will... There will be a footnote displayed and it will say that these... Basically the footnote will say that the prices that you're seeing on the screen are not as accurate as they could be because the plan doesn't offer this option. So those choices will come up later on in your search as you get to the plan results, plan details and compare plans and pages toward the end of your search. Another enhancement and this goes back to what the…Captain mentioned before with regards to plan ratings. This year, because of the amount of data that CMS has required the plans to analyze and to forward to CMS over the last three years, is now a requirement for the Plan Finder to suppress enrollment for low performing plans. And low performing plans means that those plans who have received two stars or less for three consecutive years. And so beginning this year, you'll see a screen if you want more information or you're considering enrolling in a low performing plan, there's a big icon that you'll see there on the left, a caution icon that goes along with the text. That will come up both when you're

searching on that plan, you want to find more details about it, and especially when you enroll. Basically the bottom line is beginning this year you will not be able to enroll in a low performing plan using the online enrollment center on the Plan Finder. You may still enroll in that plan but you'll have to call the plan personally and contact them and tell them either over the phone or through their website that 'Yes, I want to enroll in your plan.' Let's go on to the next slide. And we'll see another example of this. This is a representation of part of the plan results page where all of your plans that you chose will come up just in a row arranged by the... The default pre-sort is lowest annual drug costs. So when you first see this page there's also at this particular time of year... If you're not a low performing plan, you'll see over in the far right hand column, you'll have the opportunity to actually enroll in that plan if it's not in a low performing plan. But this particular example you see that the online enroll button has been what we call suppressed, which is you'll see if you look at the plan right below the low performing plan, the AARP plan, you actually see a gray button that says... It's lit up and says, 'Enrolled.' You can actually click on the enroll button and go directly to the online enrollment center and actually enroll in that plan if you don't want to shop anymore. But again with the low performing plan enrollment column you won't be able to enroll. In fact, when you click on the text or on the link that says, 'Click here for more details,' another warning will come up and it will basically tell you, 'Please think about not enrolling in this plan,' and you can enroll in the plan anyway. Here's what comes up when you click on the... Uh, 'Click here for more information to enroll in a low performing plan.' It's just basically text that tells you as I just mentioned, 'It's received low-quality ratings for three years in a row. You can if you choose to enroll in the plan, but you'll have to do it on your own. You can't do it through the online enrollment center.' Uh, something similar has happened and an example of it is on the next slide. As you know of course there are some plans

every year that non-renew their contracts with CMS, which means they won't offer any services, drug or health in 2013 under that contract number and under the name of the plan. That is they will not be providing services to Medicare beneficiaries through a contract with CMS. So that information is very important. Folks who are in non-renewing plans will receive letters of course prior to the annual election period telling them that the plan that they are currently in will be not providing services in 2013. So we wanted to simplify the information not only in the header, but actually make it more specific with regards to non-renewing plans, and so you'll see an example of the change. It's sort of an after shot of what we had before, but basically it just sort of highlights the fact that you won't be able to enroll in this plan for 2013. The next slide just shows you the text when you click on that link. Of course the text basically says, 'This plan is not offering services next year. Please look elsewhere if you want to enroll at this time.' The next slide again is if you get to the plan details page, which is you actually click on the header and go back... I'll show you what I mean on the slide previous. This is the header or what I call a header. It's the title of the... Um, it's the name of the plan with the contract number. If you click on that your plan details page will come up. That is it will give you, you know what your co-pays are for certain services, what your co-pays are for certain drugs if that plan offers drugs and so forth. Again, if it's a non-renewing plan and you go ahead and click on the plan details and the plan details page comes up for you, it will under the enroll button, which will be grayed out. You won't be able to click on it. The text will say 'This is a non-renewing plan. Click here for more details.' And if you do that you'll see the slide...the text on the slide before saying, 'This plan won't be offering services next year.' The same thing on the plan compare page, which is just another way to look at plan details. You can actually click on the plan details page, three different plans. Go up and click on a link that says compare plans and you can compare,

actually compare the plans side-by-side. If, for example, you do pick a non-renewing plan, then those details come up as well on the plan compare page. Just emphasizing again the importance and the amount of information that we try to provide on the Plan Finder with respect to the plan rating, they announce such an important part of beneficiary choice. We have rearranged and made more prominent the plan rating sort on the plan details page. As I told you before, the default sort when the page just pops up for the first time, the default sort always defaults to the lowest annual drug costs. That's the first plan that will show up on that page whether it's a standalone Prescription Drug Plan, whether it's a Medicare Advantage Plan that offers prescription drug care, or whether it's a Medicare Advantage Plan that doesn't offer prescription drug care. Well, the secondary sort that is if you choose it in the sort drop-down box, you can actually click on the plan ratings and so you will get from high to low in that particular sort. Also with the sort for...that comes up originally, you will also get depending on the cost, you will also see all of the plan ratings for all of those plans. So the plan ratings column has become more prominent in both the original sort and the secondary sort. Again, this is just wrapping up here as with now we are particularly into the annual election period right now. All plans that are going to be offering services for 2013 are required by CMS to - unless it's special circumstances for...for example, special need plans and some cost-based plan and some employer plans, must present their information for display on the Plan Finder. So all that information went up on the fifteenth. People have been able to actually shop since around the first, but of course, they couldn't enroll until the fifteenth. Now if... some people because of the timing of their initial election period and to Part B will have had to enroll in a 2012 plan if that was their choice. And now they will have to enroll in a 2013 plan, if they want to change that plan. But up until December actually you would... What is it, October? Uh, November the thirty first.

Female: *** *(unclear.)*

Jay: Yeah, 31st. Um, you will actually be able to enroll in the 2012 plan. But as of midnight on November thirty first, you will not be able to. Those plans will automatically become disabled. Because now we are required on the Plan Finder to show both 2012 data and 2013 data, for the same plan and those links are easily available. Sometimes it's confusing if you're switching back and forth to compare, for example, plan rates for 2012 versus the same plan for 2013. So we're going to make it virtually impossible for folks to enroll in the wrong plan come November 31st. Also on December 8th folks will be required to select a special enrollment period code because of course as of midnight the 7th, annual election period closes. A lot of folks have asked us if we've only gotten the question a couple of times over the last couple of weeks, but of course everybody's thoughts are with the victims of Sandy and how that may affect the annual election period. There have been no decision made and no talk has come to us at the Plan Finder whether the annual election period will be extended. It's a natural question for everybody to ask and I probably don't have to tell you this, but a decision like that is way above our pay grade and we will...If it's extended or even if it's not extended, we will be contacted; that information will be passed along. But I do want to emphasize before I close that this is a 24/7-365 tool. Millions of people actually shop the tool every year, and so you can use this tool to enroll at any time if you become eligible to enroll in these plans. If you become a Medicare eligible beneficiary and you're in your initial enrollment period, or your open enrollment period, you can go on the tool and either get assistance from someone who knows how to use the tool or use it yourself to actually enroll. So even if the annual election period is extended that doesn't mean we're going to make any changes to the Plan Finder. It's just going to mean that every...that folks, if it's extended, if it's extended will have the opportunity for several more days to enroll in a 2013

plan. But I do again want to emphasize that this is a tool that you can use every day and folks do use it every day. Thank you.

Kitty: Okay, thank you Jay. Pam, do you have anything to add any comments to Jay's presentation?

Pam: Um, no other than we... You can't tell from the slide that I showed, but we did mark like the star ratings and so you can see those easy, and I was just real pleased to see that some of the higher quality...the higher ones were... We had them in the dual eligible plans. So that was really great.

Kitty: Good. Okay, well I think at this point I will go ahead and open up the call for any questions and comments.

Operator: Thank you Ms. Marks. If you would like to ask a question, please signal by pressing the star key followed by the digit one on your telephone keypad. If you are using a speaker phone, please make sure your mute function is turned off to allow your signal to reach our equipment. Also, if you have signals for a question prior to hearing these instructions on today's call, please repeat the process now by pressing star one again to ensure that our equipment has captured your signal. Please be aware that a voice prompt on your phone line will indicate when your line is open. At that point, please state your name and tribal affiliation before posing your question. Once again press star one to be placed in the queue.

(Pause.)

Operator: And we will take our first question.

Kitty: Go ahead.

Kay: Hi, this is Kay from UNO, Indian Health Service at Fort Duchesne. And I just... We got on late and...but I did catch the part where it said we need to do the fraud, waste, and abuse training, but I didn't catch where we do that. Where do we get that information?

Pam: This is Pam. If you go to the Point of Sale FTP site, there's information up there. Are you receiving any information from the plans, like are they faxing or mailing anything to you about that?

Kay: Um, I have not seen anything. I just go to the website though.

Pam: Okay and I... Kay, I know you. This is Pam, so I can also just e-mail it directly to you.

Kay: Okay. Great.

Pam: But it's up there on the FTP site too.

Kay: Okay.

Pam: I'll go ahead and mail it to you.

Kay: Thank you Pam.

Pam: Uh huh.

Operator: We'll take our next question.

Kitty: Go ahead.

Marcia: Good morning or good afternoon. My name is Marcia. I am calling from *** *(unclear.)* The question I have is on the dual enrollment. A comment made was we need to assist with enrolling. We need to work with our beneficiaries to change enrollment if there's going to be a premium. The question I have, will CMS continue to switch our beneficiaries plan to another one? Will they automatically do that if they've been monitoring them in the past, will they continue to do so? Thank you.

Kay: Hello this is Kay Poker-Zewa. If the beneficiary chose the plan that is going to have a premium liability next year, no, CMS will not switch them. They will receive a letter on paper that tells them they will have a premium liability in the coming year and just some information about choosing another plan if they wish to avoid that premium liability. However, if CMS enrolled the beneficiary in the plan that's going to have the premium liability next year, then yes, we will reassign them to a plan where they will not have a premium liability in the coming year. Does that help?

Pam: Yeah, and this is Pam. I'm going to add a little bit to that because sometimes we, you know we help them or the patient benefit coordinators, and we help them enroll in that plan, so that's like the same thing as them selecting that plan.

Kay: That's true.

Kitty: Okay, thank you Marcia. Does that answer your question?

Marcia: Yes it does and I thank you for that information.

Kitty: Thank you.

Kay: You're welcome.

Operator: Once again press star one if you have a question and we'll take our next question.

Kitty: Go ahead.

(Silence.)

Operator: If you're using a speaker phone, press your mute function or pick up your handset.

Sharon: Yes, it's Sharon Blake with Muskogee Creek Nation. Can you go over the return of the attestations that needed to be turned in?

Pam: This is Pam. Where are you from?

Sharon: Muskogee Creek Nation.

Pam: Okay, so you probably are in several networks, Part D networks or you're receiving... You enrolled in the networks; your pharmacy enrolled in the networks?

Sharon: Yes.

Pam: So what is probably happening is when you got on that address list, and they have your fax number of the pharmacy, they were probably sending that information to whatever address got put on that agreement. So they are bombarding you. I'm sure they are. Um, I... If you haven't received anything, or you're not aware or that's not being communicated to you, you know what will happen is... Maybe I should take...put out that, um put out the training anyway and just send it out everywhere. Maybe that might not be a bad idea, so people at least have one that they're doing. But the plans are required, and they've been sending out notices saying, 'Don't forget, reminder. You do it. We have a free one.' So several plans have them. They're all out there. Almost any Part D plan has one available and it's for free. So I didn't want to bombard people with one that we put together, which is a little bit focused on Indian health unless if you've already done one already that you found. So if you don't receive it, let us know. And I wonder if we should just send it out...

Sharon: That was my other question is will you do this training again just for the pharmacies only or billing?

Pam: Um, you're in the national area, right?

Sharon: I'm in Oklahoma.

Pam: Oh, Oklahoma area. Well, they should... I wonder how they're disseminating information to...

Sharon: I don't...

Pam: The training is just really it's on your own. It's not like an in-person training.

Sharon: Uh huh. Will you be able to go and do this online, the webinar again?

Pam: Uh huh.

Sharon: But maybe our billers with our tribe can go on and listen to and have any questions for you?

Pam: Yeah, what I'm thinking I'll do is I'll go through the areas right now and make sure this is getting out to your area. We'll specifically make sure you're getting it. It's coming down that way so everybody is aware of that.

Sharon: Okay.

Pam: So which department are you in?

Sharon: I am a patient benefit coordinator.

Pam: Okay, so we'll make sure that... This information is probably not getting from the pharmacy to the patient benefit coordinator, so we'll make sure it's going there, because I don't... Most of the time in the private sector it's all being done in the pharmacy level. So we wanted to make sure we included everybody. Okay.

Sharon: I don't think it's getting to our pharmacy either.

Pam: Okay. All right, Muskogee.

Sharon: Yeah, Muskogee Creek Nation out of Okmulgee.

Pam: Okay, got it.

Kitty: Thank you Pam.

Pam: Uh huh.

Operator: And once again press star one if you have a question. We'll pause for a moment.

(Pause.)

Operator: And there are no questions Ms. Marks.

Kitty: Okay, thank you. Jay or Pam, do you have anything else you'd like to add?

(Silence.)

Kitty: Okay, well thank you very much Pam and Jay for your presentations, very informative and thank you all for participating on today's call. I would like to remind everyone that on Monday, November 5th Novitas Solutions will be hosting a conference call specifically for IHS tribal and urban Indian providers. The transition from Trailblazer to Novitas is ongoing right now for Medicare Part A. The cutoff date for processing claims was October 29th and for Part B the cutover date is November 19th and on this conference call, Novitas, who is taking over the Medicare contracting responsibilities from Trailblazers, will discuss the transition and will provide an opportunity for participants to ask any questions regarding the transition to representatives from the various departments within Novitas. And again that call will be November 5th, Monday, from 2 to 3:30 Eastern time. This is all posted on the American Indian/Alaska Native webpage at CMS, but the call-in number is 1-800-700-7784 and the pass code is 269563. Again, I would like to thank everyone for their participation on today's call. Tribal Affairs has established a mailbox for participants if you think of a question later on, or if you have an idea for an All Tribes Call, please send us an e-mail at tribalaffairs@cms.hhs.gov. Thank you very and have a great day and have a great...

(End of webinar - 52:56.)