All Tribes Call
Medicare Part D Open Enrollment, Program and Plan Finder Updates
November 2, 2012
1:00 – 2:30 p.m., ET

Hosts

Kitty Marx
CAPT Pamela Schweitzer
Jay Dobbs

Meeting Notes

Kitty Marx, Director of Tribal Affairs, opened the meeting by introducing the hosts and giving a project overview. The purpose of this call was to provide an opportunity for tribes to learn about Medicare Part D updates specific to IHS pharmacies and how to use the Medicare plan finder to enroll tribes for Part D 2013.

CAPT Pamela Schweitzer presented on Medicare Part D 2013. Ms. Schweitzer presented on the following topics: general information, coverage gap, creditable coverage notice letter, fraud waste and abuse training, plan information, processing claims, and resources.

General Information

The Medicare and You 2013 handbook is a great resource and is available on the Point-of-Sale FTP website. The handbook contains useful information and explains the prescription drug plans in detail. In particular, on page 94, there is a section on the Indian Health Service. It mentions that joining a Medicare drug plan may be beneficial and may help Indian health facilities because the drug plan pays for prescription costs. This section recommends that individuals or organizations interested in plans talk to the local Indian health benefits coordinator for more information. This information is also on the Point of Sale FTP website.

Coverage Gap

Ms. Schweitzer also touched on the coverage gap. The coverage gap most likely will apply to patients who do not qualify for a low-income subsidy. The coverage gap is 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, then the coverage gap ends.

American Indian beneficiaries who have Medicare Part D drug coverage that reach the coverage gap can come to ITU facilities. The spending at the ITU facility will count toward the annual out-of-pocket threshold. Dual-eligible patients or those receiving full low-income subsidy do not reach the coverage gap.

Creditable Coverage Notice

The creditable coverage notice is intended for people who are new in the patient benefit coordinator role. The creditable coverage is other coverage that is at least as good as the Medicare drug benefits. A penalty may apply if the beneficiary does 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 creditable coverage.

Facilities now only need to provide a creditable coverage notice to new and existing members who may be eligible for Part D services. Creditable coverage notices are to be prominently displayed in patient waiting areas. Sites must 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.

Fraud, Waste, and Abuse Training

All staff involved in enrolling and billing Medicare Part D must complete the fraud, waste, and abuse training. The training is free and needs to be completed every year. Audits are currently being conducted and facilities must prove that all staff has completed the training.

Plan Information

This year, there are a few name changes for some of the Pharmacy Benefit Management companies and some of the companies that are processing claims. These companies are going to send out notifications of the changes to beneficiaries. There is no action needed by beneficiaries. All of the name changes are posted on the Point of Sale FTP website.

The Medicare Advantage Plan is similar to an HMO and only a small percentage of our patients have these plans. The prescription drug plan and the stand-alone prescription drug plan is what the majority of our beneficiaries are enrolled in.

For those who have RPMS POS Emdeon access, a query in the eligibility report of the point-of-sale package must be made to determine which plan the patient is enrolled in. The query contains a field called “Contract ID,” which will help find which plan the beneficiaries are in.

Ms. Schweitzer then talked about star ratings. Restaurants, hotels, and movies all have star ratings, and last year CMS started a program to rate Medicare Advantage in the similar way. The stars are intended to make it easier for the beneficiary to compare plans. Star ratings for the prescription drug plan are based on 19 independent criteria focused on performance and quality data.

Processing Claims

Ms. Schweitzer next outlined changes to claims processing. Every prescription submitted must now have the prescriber’s National Provider Identifier (NPI) number. Prescriptions that do not have the NPI number will be rejected. Ms. Schweitzer then noted an increase in audits and made recommendations for preparing for audits.

Medicare Plan Finder

Jay Dobbs presented on Medicare Plan Finder updates. He first noted that more options were added for the beneficiary. Dobbs then went on to explain that it is now a requirement to suppress low-performing plans. Low-performing plans are plans that receive two stars or fewer. People may be able to still enroll in these plans, but they must contact the provider directly. Dobbs went into the details and provided examples while demonstrating how users will work through the Medicare Plan Finder website.

Questions and Comments

Presenters opened the floor to questions and comments. Please refer to the transcript for a full listing of questions and answers.

Q: 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?

A: 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 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.

Closing Statements

Kitty Marx made the following closing statement:

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. 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 Monday, November 5th 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.