Centers for Medicare & Medicaid Services

Special Open Door Forum:

Medicare Part D Reimbursements for Indian Health Service (IHS) & Tribal Facilities

November 5, 2008

2:00pm - 3:30pm ET

Conference Call Only

The Centers for Medicare and Medicaid Services (CMS) will host a Special Open Door Forum to discuss Medicare Part D Payments to Indian Health Service (IHS) & Tribal Facilities. CMS staff will present on Medicare Part D plans and beneficiary notices and IHS staff will describe IHS and tribal Part D activities. This session will highlight Medicare Part D changes for 2009, including process and website changes. The purpose of the Forum is to enhance Medicare Part D participation and to ensure IHS & Tribal Facilities take full advantage of the program.

The following topics will be discussed:

• What plans are available to IHS and Tribal pharmacies

• Who is eligible and what notices they may receive

• How to use the Medicare Prescription Drug Plan Finder to enroll beneficiaries in plans

A question and answer session following the presentations will allow participants to ask their specific questions directly to the panel members.

General information on Medicare Part D may be found at:

http://www.cms.hhs.gov/prescriptiondrugcovgenin/

Medicare Part D Special Guidance for IHS and Tribal Providers may be found at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/10_RxContracting_SpecialGuidance.asp#TopOfPage

We look forward to your participation.

Special Open Door Forum Participation Instructions:

Dial In: 1-800-837-1935

Reference Conference ID: 66655646

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and for Internet Relay

services click here http://www.consumer.att.com/relay/which/index.html . A Relay Communications Assistant will help.

An audio recording of this Special Forum will be posted to the Special Open Door Forum website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning November 13, 2008.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at http://www.cms.hhs.gov/opendoorforums/

Thank you for your interest in CMS Open Door Forums.

Agenda:
Special Open Door Forum:
Medicare Part D Reimbursements for Indian Health Service (IHS) & Tribal Facilities
November 5, 2008
2:00pm - 3:30pm ET

- Welcome & Moderator – Natalie Highsmith (CMS)
- Introduction of Presenters- Rodger Goodacre, Director of the Tribal Affairs Group, Office of External Affairs, CMS
- Review & 2009 Updates - Lynn Orlosky, Director of the Division of Enrollment & Eligibility Policy in the Medicare Enrollment and Appeals Group, Center for Health Plan Choice, CMS & Kay Pokrzywa, Health Insurance Specialist, Center for Health Plan Choice, CMS
- Review & Updates to 2009 Plan Finder Tool - Juliette Toure, LCDR, USPHS PharmD, CMS
- IHS Efforts with Part D - Elmer Brewster, Special Assistant, Office of Resource Access and Partnerships at HQs, Indian Health Service
- IHS Efforts with Part D - Pam Schweitzer, Pharmacy Informatix Consultant, Office of Health Programs, Indian Health Services, Phoenix, AZ
- Open Q&A- Natalie Highsmith (CMS)
- Closing Remarks- Roger Goodacre (CMS)
- End of Call- Natalie Highsmith (CMS)

Audio File for this Transcript:

http://media.cms.hhs.gov/audio/SpcFrmODFMedPtDUpdatesIHS.mp3

CENTERS FOR MEDICARE & MEDICAID SERVICES

Special Open Door Forum:
Medicare Part D Reimbursements for Indian Health Service (IHS) & Tribal Facilities

Moderator: Natalie Highsmith
Conference Leader: Michael Lyman

November 5, 2008
2:00 pm ET

Operator: Good afternoon. My name is (Cindy) and I will be your conference facilitator today.

At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum on Medicare Part D Reimbursement for Indian Health Services.

All lines have been placed on mute to prevent any background noise. After the speaker's 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 question, simply press the pound key.

Thank you Ms. Highsmith, you may begin your conference.

Natalie Highsmith: Thank you (Cindy) and good day to everyone and thank you for joining us for this Special Open Door Forum.

Today's CMS staff will present on Medicare Part D Plan, Part D changes for 2009, and beneficiary notices and Indian Health Service Staff will describe Indian Health Service and Tribal Part D activities.

Today the following topics will be discussed. What plans are available to IHS and tribal pharmacies? Who is eligible and what notices they may receive? And how to use the Medicare Prescription Drug Plan Finder to enroll beneficiaries in plans?

After that, we will have an open Q&A.

I will now turn the call over to Rodger Goodacre who is the Director of the Tribal Affairs Group and also with Human Affairs here at CMS. Rodger?

Rodger Goodacre: Thank you very much Natalie and let me add my welcome to Natalie's - to today's call. We very much appreciate your willingness to take the time and effort to join us and learn more about Medicare's Part D benefit and how you can use it to help tribal members receive the benefits to which they are entitled.

We have a big busy panel today. We have five presenters, all of whom have lots of information to share with you. Before we start that, I'd like to remind everybody that we have another resource where you can actually put some faces to the voices you're going to hear on today's call.

We did a Medicine Dish Show. Many of you are familiar with our Medicine Dish Program. It's a monthly TV broadcast, Webcast like we do on American Indian and Alaskan Native Program, CMS Interactions with the programs.

You can see the show that we did on Medicare's Part D benefit by going to the following Web site: videocast, all one word, videocast.nih.gov, click on past events. Go to CMS there and you'll find all of our programs including the one from October 8th on Medicare - on the Part D benefit and how it works with the Indian Health Service and Tribal Programs.

Okay, let's push off into today's program. The first two speakers, you'll be hearing from will talk generally about the sorts of notices, various activities that you're going to be - that beneficiaries are going to be receiving from Medicare and from our contractors and learn a little bit more about updates so low income subsidy and other activities that surround that.

Then we're going to be - we'll hear from (Juliet Turae) who's going to talk with us about updates to the Medicare Plan Advisor and how you can use to move - to make sure the beneficiaries are enrolled in the program that best serves them.

So let me first turn to our first presenter, it's (Lynn Orlaski). (Lynn Orlaski)'s going to share with us information about all the notices and other activities that beneficiaries will be seeing. (Lynn) turn to you please.

(Lynn Orlaski): Thanks Rodger. I'm actually just going to give a brief overview of some of the key enrollment aspects that you might be interested in. As

you know, starting on November 15th, the Fall Open Enrollment for Medicare begins and that continues through December 31st and that is the time when we encourage all interested individuals to enroll in a drug plan and review your current coverage that you may have.

This is the main enrollment period for both Medicare Advantage and Part D and generally individuals who don't enroll by December 31st, generally need to wait until the next year, unless they meet certain special opportunity criteria, such as if you quality for extra help.

Now one of the key messages that we have provided on the videocast and that we do provide folks in the Indian Health Service and Tribal Facilities and Urban Indian Programs, is that if you receive health care from, again, the Indian Health Service or the facilities or the Urban Program, that it's important that you check with your Indian Health Care provider before you make any changes to your health care coverage.

This is extremely important and as the messages that have been provided to you all, that by working with your benefit coordinator at your local facility that you can, you know, basically insure that you're - that you helped your community now and in the future.

But one of the things that is, you know, one of the key points in questions that we do receive from individuals who do receive health care from Indian Health Services, whether or not, what are the other enrollment periods that individuals would be able to utilize?

As I mentioned, generally the annual fall open enrollment period is the main period to make changes and because the Indian Health Service coverage is considered coverage that is as good as Medicare, generally

unless you meet other opportunities, this is the main period where you would make changes.

There is an additional enrollment period that occurs from January through March 31st, that if you happen to have the eligible for have coverage through the -a Medicare Health Plan, called a Medicare Advantage Plan, that you can actually join which or dis-enroll from, but generally the main - again the main time to make changes is November through December 31st.

And essentially, if you are interested in - if you are currently enrolled in a plan and you want to make changes, if you simply want to go back to the regular original Medicare Program, you would simply submit a request for that plan to dis-enroll or you can also call 1-800-MEDICARE.

Or if you are interested in enrolling in other programs, another plan, you can either contact 1-800-MEDICARE, you could also look at medicare.gov, which (Julia)'s going to speaking to shortly and you can also contact the plan directly and ask them about the different options that they offer.

But again, I just wanted to stress that, you know, make sure that you check with you Indian Healthcare Provider before you make any changes to your health care coverage.

The other - essentially I want to advise that, if you are currently enrolled in a either a Medicare Advantage Plan or a Medicare Prescription Drug Plan, you should have already received a notice in October that should outline all the specific changes in your - in the plan that will occur for 2009.

So, if you haven't received that notice already and you are currently enrolled in the plan, you should contact your plan directly and they should be able to provide you with a copy of that notice.

With that, I am going to turn this over to (Kay Hooperziwa) who's going to talk about the different opportunities for individuals who are eligible for extra help.

(Kay Hooperziwa): Thanks (Lynn). There are a number of processes that occur in autumn each year that are associated with the deeming status of our beneficiaries and then the circumstances of individual's plans which may put them at a disadvantage if they remain in that plan and how CMS reacts to that.

These two main activities occur in the autumn we call redeeming and reassignment. Redeeming is CMS' process to determine if beneficiaries who automatically qualify for extra help in 2008 will continue to qualify for that extra help in 2009. CMS uses state data and SSI data from Social Security to determine who continues to qualify in 2009.

The redeeming process begin with the mailing of notices in September on gray paper to individuals who will not automatically qualify for the extra help in 2009. Included in this mailing was, an SSA Extra Help Application and prepaid return envelope.

Individuals were encouraged to complete and return the SSA Application in order to requalify for extra help for 2009.

CMS also mailed notices on orange paper, it was actually a pale orange paper, to individuals who will continue to automatically qualify for extra help in 2009, but who's copay level is going to change effective January 1.

Individuals who experience no change, in other words, they're going to deemed again next year, their copay will remain the same, will not receive a notice.

The other main process that occurs in the fall is reassignment. Reassignment is CMS' process for protecting beneficiaries from plan termination or premium liability in 2009. If an individual's plan will have a premium in 2009 that is above the regional low income premium subsidy amount, also known as the Regional Benchmark, that individual would be responsible for paying a portion of the plan's premium, even if he or she had 100% premium subsidy.

To prevent the person from having this premium liability, CMS will move him or her to a plan where the premium will be covered in full by the extra help.

If the individual's plan is terminating effective December 31st, CMS will reassign subsidy eligible individuals to insure that they have prescription drug coverage on January 1, 2009.

Individuals who will be reassigned by CMS to new plans, will receive notices on blue paper in November. Individuals who plans have an increase in premium, may choose to remain with their 2008 plan. The notice will describe their premium liability if they remain and give some directions for continuing their enrollment in their 2008 plan, if they wish.

Individuals who's plans are terminating, are free to choose a plan other then the plan which CMS has chosen for them. In all cases, CMS encourages beneficiaries to make sure that the plans in which they are enrolled meet their prescription drug needs and offer convenient access.

Rodger Goodacre: Okay. Thank you very much (Kay) and thank you (Lynn). Let me turn now to (Juliet) who's going to speak with us about how to use the Medicare Plan Finder, the on-line tool to help enroll people in the appropriate plan?

(Juliet).

(Juliet Turae): Okay. Thanks Rodger. A nice segway I guess into the Plan Finder. I wanted to kind of pull information that you received from (Lynn) and (Kay) and how it relates to the Plan Finder.

So, just a background on what the Plan Finder. Is basically, it's a tool that helps beneficiaries look at the various benefits and costs of the prescription drug plan that Medicare offers to its beneficiaries.

And so if provides a wide variety of information, ranging from the premium costs to whether a plan offers gap coverage to specific costs for drugs and what their formulary placement is and the specific copay by the plan, as well as quality and performance rating that is expressed in five star ratings and also actual data.

So, for the specific population that, you know, we're dealing with here, I'd recommend using a personalized search and it would automatically bring up the co-pays, the extra help co-pays for which

the beneficiary would qualify for, based on the information that is in Medicare's database and also coincides with the letters that they would receive.

It would also pull up the current plan information. So, if they were reassigned to a specific plan, it would also see that specific plan to which they've been assigned.

It would also show the current plan, so if they're currently in a plan, it also shows that information as well.

However, the personalized search isn't an option, for example, if you don't have the Medicare number of the Part A or B effective date information that you would need to move forward with a personalized search, then the person can perform a general search and see the plans in that area. And you would have to answer the questions that are involved in a general search and simply answer that you do receive help from Medicare and Medicaid.

Beyond that, I wanted to also let you know that we've made enhancements this year. We tried to take all comments and ideas from previous years to try to make our tool easier to use and more helpful and I wanted to go over some of those enhancements that you might find helpful.

And that would include drug entry. So once you complete the steps for a personalized or a general search, you'd want to enter the drug that the person is on to get the most detailed and tailored information for that specific person.

So, entering the drug should be easier. We're also improved the verbiage, so that people know that over the counter and dietetic supplies are not searchable on the plan finder.

As you all know, over-the-counter drugs aren't covered Part D. Diabetic supplies are. However, we're not able to provide the pricing on Plan Finder.

In addition to that, for those that have extra help, we've added some information that helps the beneficiaries understand the specific costs across the different phases of the Part D benefit. So, there may be times, for example, if a plan offers a zero dollar generic benefit and the deductible, and initial coverage level, they would - you would be able to see this information and accurately calculate what the cost would be for that specific benefit.

And also, something that might be helpful for people that are helping these beneficiaries, is we now offer information on the state and manufactured sponsored pharmaceutical assistance program. So you'll find links to get more information on that to help further reduce costs.

And just on a final note, I wanted to let you know, that starting November 13th, we will be revealing and publishing the plan rating information. So the five star ratings that I was talking about earlier, you'll be able to see how these plans perform in the areas of customer service and other related areas.

And then, as (Lynn) mentioned earlier, November 15th is the first day that you can begin enrolling in 2009 plans and so therefore, we'll turn on the enroll button for the 2009 plans and you can actually submit an

on-line enrollment application through the Medicare Prescription Plan Finder.

And that about wraps it up for me.

Rodger Goodacre: Great. Well, (Juliet) thank you very much. That's the quick summary and update of where we are on Part D this year here at CMS.

Let me turn now to our HIS presenters. They're (Elmer Brewster) and (Pam Switzer). Let me first turn to (Elmer) and - who's going to provide us a brief overview of where you are. (Elmer).

(Elmer Brewster): Thank you Rodger. Good afternoon everybody. I'm just going to provide you with a quick update and overview of third party revenue. I'm going to talk about eligibility a little bit. I'm going to describe the numbers of Medicare and Part D beneficiaries that we have in our system.

First of all, third party revenue, Medicare, Medicaid, private insurance, State Children's Health Insurance Program and Part D revenue, which is the topic of this conference call is important to the mission of IHS, which is raising the health status of Indian people to the highest possible level.

Third party revenue, revenue that we bring in, pays for up 50% of the costs of providing health care in our hospital and clinic facilities. Overall IHS collects about $750 million from third party payers. Medicaid's our largest, over $500 million. Medicare's about $160 million and private insurance is about $90 million.

So as you can see, you know, we pay attention to third party revenue and it's very important to our mission.

The revenue also reduces or saves CHS expenditures, because CHS is secondary to other alternate resources. If we use a third party resource first to pay for CHS referrals, this will allow CHS dollars to be spent on other referrals. So it just extends our CHS budget.

Third party revenue also provides access to other private providers. Should our patients need to go to the Emergency Room and be in another community or able to use private sector providers with their alternate resource, such as Medicare, Medicaid.

And lastly, it's extremely important during patient registration to obtain all third party information, including the Part D information. If this information is not captured up front, then any pharmacy service provided will not be billable, and then revenue will not be realized.

For 2007 in terms of third party eligibility that's in our PMS and in our system for the 1.4 million users that we have, Medicaid represents about 35%. So about 35% of our users are on the Medicaid program.

Medicare is about 8, 9% and there's all the various combinations of Medicare, of course, A, B, A and B and private insurance, A and B and Medicaid. There's all the different combinations. But that represents about 8%.

Private insurance enrollment in our patient registration system is 22%. So that's about one in five. But any time I used the 22% figure, I must mention to you that about half of those individuals are enrolled in tribal self insurance and Indian Health Service cannot bill tribal self

insurance by law and in many locations tribal self insurance won't pay for contract health service referral either.

So we've got - so the 22% is really, you know, what I estimate is about half of that is true private insurance.

And then 35 to 40% have no insurance at all in our system.

So overall about 50% of the IHS users have some sort of third party coverage. For Part D enrollees in our system, the IHS currently has about 122,187 patients with Medicare, some combination of Medicare. About 35% have Medicaid and Medicare and about 25% have Medicare A and B and private insurance. Thirty percent have only A and B. The remaining 10% have other combinations, such as, you know, only A or only B something like that.

Since IHS is creditable coverage and our beneficiaries are not required to enroll in a Part D plan, we need to make sure that our Medicare patients that also have Medicaid, that their Part D plan information is recorded in our patient registration system, so that we can bill and collect revenue from the various Part D plans.

Currently, of these beneficiaries about 50,000 are showing some sort of Part D plan in our patient registration. Now as you know, in our patient registration there is an expiration date, and so there may be some duplication and some patients that their - the expiration date is in there, but they're still be counted.

So about 50,000. So that's in our current system.

One last point, I understand that in talking with our point of service staff of POS staff, that Part D payment processors reject some of the electronic payment requests for not having either the right name or inaccurate (NCPDP) number or some sort of error in the processing and these result in rejects and they're- they stay in our system and end up in the POS system and if they're not worked, if they're not followed-up and the errors not corrected, then we would end up not getting paid for those claims and we'd be leaving money on the table.

And so, that's - you know, like I mentioned before, the revenue that we collect really is used to operate our hospitals and clinics.

So, in a nutshell, that was my brief overview.

Rodger Goodacre: Thank you very much (Elmer), that's - it's always great to feel the - to put the efforts that people are doing in a prospective and clearly everybody's always too aware of the important interactions between our programs. As (Elmer) suggests, as (Elmer) tells us, payments from CMS represent somewhere in the 25 plus range of all operating payments, and that's a pretty significant portion of anyone's budget.

Let's turn now to if we can to, (Pam Switzer) who's going to also provide us with some more particulars on how you're working with Medicare's Part D benefit. (Pam).

(Pam Switzer): Okay. As I get started here, the first thing I just wanted to mention, is some of the information that I'm going to be talking about, I know that folks will want a copy of it and so I prior to this call today, I actually put it up on the ftp site. That those of you that work point of sale and use point of sale know what that is, but I will tell you the name of that

site. It's available for tribes and IHS. And if you can't connect to it, it's not meant to be closed, you just need to talk to the site manager.

But for most of you, you've been using the site for quite a while. And the address is, you know, ftp://ftp.ihs.gov/rpms/pos. So I'll say that one more time, basically if you just type ftp.ihs.gov/rpms and the point of sale, pos, it'll pull it up.

And we can always, the next thing I was going to talk about is the point of sale lister that's available. We started it over the summer, I think. And we're starting to use that more and more and it's actually very timely because, as we're getting a lot of these agreements in place, we get a lot of good information from the plans and we're trying to just disseminate that out to everybody that's interested in billing.

The folks that it would be really to be on it and if you know that - if you're not on there, would be the people that do the enrollment. These are the patient benefit coordinators. There's a lot of information too, that we're actually disseminating on there to them and so usually, we ask to forward it to them, but it's just as easy for them to go ahead and get on that lister. It's a point of sale lister.

If you don't have information on how to get on there, you can contact us afterwards and we can send you the directions, even though you can go to the IHS lister site and also find it there.

And just to give you an example, information I know that was sent out yesterday, was there was a flyer that Caremark now has acquired Long's RX America. So this is just so we all can kind of keep up with what's going on out in the industry.

So, okay. Then the next thing I wanted to talk about, which is really, I know, people are kind of interested in and I will offer this afterwards. I know that a couple of areas have already asked and I told them that I would do this over the next month, is just meet specifically with your area.

Because what I'll be talking about is pretty general nationwide. I'll be talking to both tribes and IHS and then there's a lot more specific, depending on which region of the country you're in.

And what I'm going to talk about is the prescription drug plan, also known as PDP's that are available for 2009. And I put up on that ftp site kind of the break down and I marked them, the ones we're really kind of focusing in on. And those tend to be the ones that would - our patients would not have a deductible - would not have a premium, so patients wouldn't have a premium.

So there's a call on this mark and if they have a dot on there, that just means there's no premium. So in general our patients tend to be in that group, the dual eligibles they seem to be in that group. So the plans that have a dot on them and then there's no premium.

If - this year there were some changes that probably are going to affect this significantly so we wanted to get that word out because if we help them enroll, if you're patient benefit coordinator and you help them enroll in a plan that was available in your state, because we had an agreement with it, and now this year the plan is not available, the plan is available or now has a premium in it, and it doesn't have a dot in that square there, then they're going to be charged a premium.

So we want to try to at least make you aware of those, so that the patient - they may be very happy with their plan and their coverage, but they need to know if they don't move, if they're in a plan that doesn't - that has a premium now, they're going to be charged a premium.

So we just want to make sure that they're all educated on that. And I know some of you have already started doing that, because we've had requests for that.

So, I'll just sort of give a summary, if you - you can actually see all this up on the ftp site too. Just in general, I'm going to talk about kind of the big things.

In general, as we figured over time, there's going to be less plans available then there were in the beginning and I put the summary up there. Probably the big news, is that Humana, which a lot of us enrolled in that first year, basically does not have any plan now in all IHS countries that does not have a premium.

In other words, there's a premium with all of them. So anybody that's enrolled in Humana, if they don't mind paying a premium, they can stay put, but if they don't want to have a premium, they're going to have to move out of there.

So that's kind of big news, 'cause I know here in Arizona we had a lot of people in Humana.

The other one is AARP. There's very few plans nationwide now that do not have a premium. In other words, they all have a premium.

So if people are enrolled in AARP this year, it's not going to be a great year to - for them to in there. They'll be charged a premium if they're dual eligible.

The other one is Healthnet, which is a big one for us too. That tended to be a real big one nationwide. That one there, I think, Arizona's the only state now that has - where Healthnet does not have premium so it's for the dual eligible patients. So all the other ones, it's going to be charging a premium.

And I'm letting you know all of this, and I know there might be questions on this and I'll probably have to say it a couple different ways, but basically what happens, the patients if they stay there, that's find, it's just they're going to be charged a premium and most of them probably wouldn't want to do that in our group, in our population.

There's been a decrease to Welcare. They had a lot of plans last year. They have less this year. SierraRX is still there. They increased. The ones that increased were First Health, Silverscript, which we all have an agreement with - that's through Care Mark, they increased too.

Health Screen decreased. Coventry, which is Medicare RX Rewards, they went down a little bit. And then there's two new plans, one is Prescriber RX Blond. That's new and that's in 13 of our states have that one. And we already have an agreement in place with them, so that you'll be okay there.

And the other one is Global RX, and that's in three of our states. That's a new plan too. And that one there, we have an agreement in place, that's through Medco.

So for the most part, everything else is pretty - looks pretty consistent. Those were just the main highlights, there are the main changes.

Now if you look at the spreadsheet, when you open up that spreadsheet up on the ftp site, it has the summary right there. And along the bottom it's basically listed by area. You'll see - and I'll just pull up here - I'm just pulling up Aberdeen, 'cause it's A. Alaska's there too, but A. And what I did, is I kind of made it color coded. Those of you that have known me for a long time, know I like color codes.

Red means that the plan - last year this plan was a dual eligible plan. It was a plan that a dot in it. This year it does not. So what's the importance of that, is that folks that had that plan last year, if they don't move out or they're not put into a different plan, they're going to have a premium or have to pay for part of the premium there.

So you can look. And then I marked the ones all the way across. They're like in yellow. It's just continuation from last year. A blue, and I put that in there, is because the agreement's still in process and that's - I'll talk about the agreements in a little bit here and then a green is a brand new plan for this year, which I mentioned those two, so we only have two new plans this year.

So if I were looking at this sheet, I would kind of focus on the red ones, because those are the ones you want to make sure that if the patient, if we help them enroll, then to make sure that they understand what the consequences of this is -as long as they don't move out of that plan.

Now, if CMS auto enrolls them in that plan, then CMS will help move them into a plan, like it was mentioned earlier, into a plan that doesn't have a premium.

Okay. So that sort of it. I know that there's a couple of states that really it decreased a lot. There's only a few plans in the state.

But for the most part, there's still plenty of opportunities and plenty of alternatives.

I'm going to mention a little bit about the agreements. In the first years, it took a little while just to get used to all new, just the new process of getting the agreement through. But thanks to headquarters, you know, (Ann French), (Captain Watson), Dr. (Olson), you know, that whole group here, that whole department, plus just the process with our legal counsel, we've been able to pretty much get the agreements through pretty painlessly now.

So almost all of the payers know us real well. And right now, at this moment, we're actually receiving a lot of the paperwork or the networks or addendums or updates on the 2009 plans, so those are being reviewed.

I expect we'll be all finished with those. They won't get hung up anywhere like they have been in the past. A lot of this (Rear Admiral Pitman) kind of paved the way for us. And so, we worked out a pretty good deal.

And those of you that know (Geri Taylor), she's been helping a lot in the office, kind of keeping on top of that too. So we're actually a lot

more organized then we were in the past. So I don't think we're going to have too many issues.

Probably the biggest thing that we always need to know, is keeping addresses all updated and I sent an email out a couple of months ago and tried to make sure that the addresses all are current. So - and everything - and all that information is current.

And if you can give us feedback, if the addresses are wrong - continually wanting that feedback, because there's a lot of little places where the address can be and we're really trying to clean that up, making big efforts to try and clean that up.

For those tribes that are on the call, I highly encourage you to pretty much do the same thing we're doing with the Indian Health Service and get an agreement with everybody, because then it just makes it so much easier, instead of we don't have to move them to a different plan, in other words, we have agreements in all the plans.

And so then it just makes it a lot easier instead of wondering which plan we're going to have to try to get an agreement with in next. And there's a list up on the ftp site, I put, that lists all the plans that are LIS plans, and so that's basically that we're going off of. Anybody that's an LIS plan, we want to make sure we have an agreement with.

If a patient happens to - a member happens to be in a managed care plan, most of the time these agreements, these network agreements include processing for those managed care plans. Every once in a while, there might be an additional addendum that needs to be added, but we're - as we're requesting all of these, we're requesting, you

know, every network that they have Medicare Part D patients. They're providing it to us, and that what's we're getting assigned.

So it's getting, hopefully, getting better this year. The other thing I wanted to mention is in the point of sale package, there is a - it's under the report section, for those of you that use point of sale. It's called the Eligibility Transaction.

You hear a lot of us refer it to as the E-1 and we would highly recommend, that's a very valuable tool, you put on there another set of instructions, because what most people don't realize is, that it was enhanced, that whole feature was enhanced a couple of years ago and it now has the ability to be able to look ahead to see what plan a patient may be in.

So, I'm not sure when CMS is going to be displaying this - which plans like the auto enrollees are going to be in. You would be able to - right now you can go 90 days ahead and look and see what you're in.

So up there, I've included the instructions for how to do that, and all that you do is, you list the name. It asks what time period you want to look for and it defaults to today, but if you just two plus 60 or somewhere in the 2009, you'll be able to see what plan they're in for 2009. And so the instructions of how to do are up there on the ftp site.

Vaccines. This is going to be something new this year. I also included a handout up there on that and what this is, is we actually been trying to do our best to sign all these agreements for vaccines. I encourage the tribes to do the same thing.

Point of sale had to make some adjustments and it's also those that are currently in test right now and it'll be coming out on Patch 28. When you see those come out, when you see that come out, shortly afterwards the instructions on how to bill vaccines - and this is vaccines that are administered in a pharmacy.

So what happens now, they now, Part D will now pay for the administration of Part D vaccines, which part of the training is going to be which are Part D and which are Part B. Part B like in boy or Part D like in dog. We'll be able to know which vaccine falls under which coverage and then they'll - the pharmacist if they're administering the vaccine in the pharmacy are able to bill to point of sale with that.

So, that'll be coming out. I'm not sure when the patch is coming out. It's - (Chris) is on this, she could probably respond to that, but I imagine it'll be coming out here in the next few weeks, because I know that piece was already tested.

Let's see. Then I wanted to talk a little about the creditable coverage letters. I know that everybody's been working on them trying to get them out. There was a letter or email that came out about a month ago on this. And I know everybody's been working on it.

CMS has been so great to work with over the - this past year, just in getting feedback and I just highly encourage you, not only for the topic that I'm going to talk about now, just when you're having issues and problems they really are open, they want to hear when people are having issues, when plans are not understanding correctly what needs to be done, when patients are having problems.

They've been really helpful just in helping getting some of these resolved and I've noticed that they've sort of even changed some of the rules and things so that the patients don't get hurt. They really are trying to be focused on the patient.

But one of them, and this came from the field, this came really the business office, because I think they were putting this out, the creditable coverage letter, that you spent hours sending it out. This year you're doing it again, but I - it looks like this will be the last year it's going to be done this way.

They've been open to the change in the process by how we do the creditable coverage letter. The most important piece and CMS may correct me, is that the patient understand that they are - that they have creditable coverage. They need to understand and know that.

So when they go to a plan, that's something that they mention, so they don't get penalized for that. So it's real important. That's why they want to make sure the word is out so well and so what will happen is, and I'm fully open for suggestions. We're going to be drafting this here real shortly and so any input would be appreciated, but this is sort of the general high level view of what this is sort of going to look like for next year.

Is that, it would be - if you have input, we're going to propose that all the new beneficiaries would receive a letter. So that part's going to stay the same. All new beneficiaries are going to receive a letter.

If a beneficiary had previously had a letter, like three years ago they had a letter and they need to get one again, because they're going to be

changing plans, the facility needs to have an easy way to be able to provide that letter upon request.

So if you use the software that has been distributed, it should be fairly easy to be able to print out. If they've seen at their clinic or if they're seen at your facility, you'll be able to print that out.

And then also to have some kind of educational materials in our reach, signage in the clinics, information basically letting the Medicare beneficiaries know that they do have creditable coverage and that if they want/need to provide proof or they need to get a letter, this is how you get a letter to show that.

So we want to make sure that they all know that they have that coverage and that it's a very simple process to get a letter, if they don't have a letter already. So that's sort of the general high level view of it.

The last little topic that I'm going to talk about right here, before questions, are (NCPTP) on-line. This is something and as soon as we get through all these agreements, get the agreements finished, the network agreements finished for Part D, you're going to start seeing a little bit on this for the tribes.

I'll be working through your folks there to do some education on that and getting set up, because what's happened now, is we're sort of getting in this technology world and all the paperwork and we have changes of address and changes of things, they're actually getting on-line. You can do it on a Web browser.

So they've offered to provide some specific in-services just for the tribe, that we're going to go ahead and show you how to do that, so

you can get your on-line and you can make you - all your changes, your payment address on-line. This is for the tribes only that I'm talking about.

So you'll be seeing information come about that. Probably here within the next month, and - so you'll be able to manage it on yourself - by yourself.

So the Indian Health Service we'll be doing that a little bit more centrally, but what will end up happening is, we'll - there's going to be some education, because it'll probably be managed, the address changes will be coordinated by the area and then we'll need to kind of work on how to get that process worked out.

But then, if they want to view the information, that all can be managed too. So we're sort of decentralizing this a little bit, but we also want to make sure that it's controlled, 'cause those address changes are real big, especially the payment address changes.

So those most likely will have a separate process doing the actual physical address changes.

So we're hoping that this is going be able to make it a lot simpler. So you see, we can trouble shoot and see where some of the problems are with the addresses and maintaining and keeping them accurate, and keeping correct contact information there.

And I think, Rodger do you think I hit everything.

Rodger Goodacre: (Pam) thank you very much. That was a very comprehensive and very helpful presentation and I know I learned a lot from what you shared with us.

Well that is - that's it from the CMS and IHS presentation side and I think what I'd - we could best do now is hear questions from everyone and, hopefully, not only hear questions but answer them.

So, let's turn it over - let me (Natalie) how do we proceed please?

Natalie Highsmith: (Cindy) if you could just remind everyone on how to get into the queue to ask a question and everyone please remember, when it is your turn, that you restate your name, what state your are calling from, and what provider or organization you are representing today.

Operator: Absolutely ma'am. At this time, we'd like to ask anyone who has a question, to please press star one on your telephone keypad.

We'll wait for just a moment for the Q&A Roster to compile.

It looks like our first question is from (Mariah Ralston) from Washington. Your line is open.

(Mariah Ralston): Hi. Can (Elmer) emphasize more on tribal self insurance and how - I think he mentioned it was not billable by law.

(Elmer Brewster): Yes this is (Elmer Brewster). And can - I guess everybody can hear me all right. In the Indian Healthcare Improvement Act, and I don't have the citation in front of me. I'm thinking it might be section 207, something like that. But in that act, it says that "ISH cannot bill tribal self insurance plan."

(Mariah Ralston): The tribes can bill tribes?

(Elmer Brewster): Excuse me.

(Mariah Ralston): Tribes can bill tribes in IHS?

(Elmer Brewster): Yeah, tribes can and that can be worked out between the tribes, but IHS cannot bill the tribal self insurance plan.

(Mariah Ralston): Okay. Thank you.

(Elmer Brewster): Okay.

Operator: Our next question is from (Cedric Giton) from Arizona. Your line is open.

(Cedric Giton): Good afternoon. My name (Cedric Giton) calling from the Tucson Indian Health Service, Tucson area. My question is for (Pam). I just needed to get the Web site address again, so I can get the information downloaded for the people here and also the alternative to Humana, because Humana's a bit component of our payments here, our Medicare Part D in the Tucson area.

Other then the Healthnet and Sierra are there any other components coming on-line that we can use to be a Part D?

(Pam Switzer): Not for Part D. Arizona only has two.

(Cedric Giton): And what was the Web site again, so I can check it?

(Pam Switzer): Okay, it's on the ftp site. It's a...do you know where the ftp site is (Cedric)?

(Cedric Giton): No ma'am. I'm trying to find it.

(Pam Switzer): Type - just type in ftp.ihs.gov. And then if you just click -open that up and then click on rpms, there's a folder called rmps and inside that folder there's another folder called point of sale.

(Cedric Giton): As you know, we have a great security system here.

(Pam Switzer): Yeah.

(Cedric Giton): And it locked things up.

(Pam Switzer): I have a better idea. I'll just send you the link.

(Cedric Giton): Thank you. Thank you very much.

(Pam Switzer): Okay.

(Elmer Brewster): Rodger.

Rodger Goodacre: Yes (Elmer).

(Elmer Brewster): I have a question about the - kind of a general question about the Medicaid programs and for the - for our dual eligibles are the states limiting what plans they have set up for the dual eligibles for, you know, for the Medicaid and Medicare patients that they have?

(Pam Switzer): Do you mean zero premium plans by region?

(Elmer Brewster): Well, I'm just thinking, it seems like in the past some states have arranged to have - have arranged agreements with other - with Part D plans in their states. And had those plan, made those plans have access to the dual eligibles enrolled in Medicaid in their states?

(Pam Switzer): That might be a function of a state pharmacy assistance plan if a state has such a plan. Not every state does.

(Elmer Brewster): Okay.

Operator: Are you ready for our next question?

(Pam Switzer): Sure.

Operator: Our next question is from (William Ezell) from Washington. Your line is open.

(William Ezell): Yes, my name is (William Ezell) and I am a shift volunteer coordinator in (Taleds) county and I'm not familiar with the Web site. I've never used it and I'm just learning about the Indian Health Services, because it's been recommended that we make - do more outreach with the Indian community.

So do I need to give you my email address? Can you clarify how I would get to the Web site?

(Pam Switzer): I'm going to talk to some of these. What is your email address? And (Jerry) listen to this. I have someone else who's going to be sending them. I just sent (Cedric)'s already. What is your email?

(William Ezell): Okay, williame@lowercolumbiaCAP.org.

(Pam Switzer): Okay, I'm talking with (Jerry Taylor). If you could send him directions of how to join the lister and then I'll send you the link to the site.

(William Ezell): Thank you very much.

(Pam Switzer): You're welcome.

Operator: Our next question is from (Dara Elliott) from Oklahoma. Your line is open.

(Dara Elliott): Sorry I don't have a question. Sorry.

Operator: Our next question is from (Judy Miscamp) from Oregon. Your line is open.

(Judy Miscamp): Thank you. My name is (Judy Miscamp) Health Director for the Confederated Tribes of (Selet). We offer a pharmacy program, but charge a minimal fee to the direct service patients and I was wondering does that still mean that they have creditable coverage though and should get a notice?

(Lynn Orlaski): Could you repeat that please?

(Judy Miscamp): Can you hear me?

(Lynn Orlaski): Yes we can.

(Judy Miscamp): Okay. We offer a pharmacy program in our clinic, but we charge a minimal fee to the direct care patient. Does that still mean that they

have creditable coverage and should get a notice informing them that they have creditable coverage?

(Lynn Orlaski): The, I mean, the criteria for creditable coverage is actually in a different component within the same group that (Kay) and I both work in. This is (Lynn).

I mean, generally if it's IHS like coverage, all coverage is provided by IHS or the facilities is considered creditable coverage. But, you know, as far as the notice that's required, I know that the folks in our private health insurance group that work on the disclosure statement, would probably be best to have answer that.

But again, unless I'm misunderstanding something, everything that should be - all coverages provided by your facility should be considered creditable coverage and then subject to the disclosure.

But...

(Pam Switzer): Okay, we'll send it out.

(Lynn Orlaski): Okay. I mean, if you want to send a - if there's a question on, whether or not, it meets the Medicare standards, you know, you could forward that question to Rodger and we could get that confirmed. But I don't that there's really an issue here with IHS coverage.

(Judy Miscamp): Okay.

Rodger Goodacre: That's certainly our understanding and not to confuse matters, but I think to follow-up what (Pam) had mentioned earlier, we are working with the Indian Health Service to determine reasonable procedures in

which we can lessen the burden of having to send out that creditable coverage letter each year.

However, for 2009, for this upcoming year, in this current period, you are required to send that notice out as you normally have been since the beginning of the program.

(Judy Miscamp): Thank you.

Rodger Goodacre: You're welcome.

Operator: Our next question is from (Judy) from Arizona. Your line is open.

(Judy): Yes, my question was on the tribal self insured. I know IHS can't bill the tribal self insured payers. If we're not IHS and we're not 638, does that bill apply to us?

(Pam Switzer): I was going to say no.

(Elmer Brewster): Yeah, this (Elmer). In section 207 of the Indian Healthcare Improvement Act that just applies to tribes - to Indian Health Service.

(Judy): So tribes are okay?

(Elmer Brewster): I believe tribes would be okay, yes.

(Judy): So if we're being denied from HMA and all those that are claiming to be tribal self insured, who would we get something in writing from saying that we're no - we're no longer under IHS?

Rodger Goodacre: I think you would probably send them a letter directly, saying that you're a 638 program and kind of appeal the, because that's really denial...

(Judy): Yeah.

Rodger Goodacre: ...and you can appeal it, so I would write them a letter.

(Judy): Okay. All right. Thank you.

Operator: Our next question is from (Judy Cranford) from Utah. Your line is open.

(Judy Cranford): Hi. I have two questions from me. (Pam) one is for you. Could you send us that Web site too? I cannot open it up. It says access has been denied.

(Pam Switzer): Okay.

(Judy Cranford): And the second question is, we have our own pharmacy program and it's a 340B program. We've been told we can't be a provider for Medicare for Part - in the Part D program. Nobody can seem from CMS to answer that question. Can anybody give me any information why?

Rodger Goodacre: This is Rodger. I - why don't you email me that? I can't figure for any reason that you know, we don't have any provider enrollment people here at the table with us and we can follow-up on that. But I mean, additionally, I can't see any reason why you couldn't be if you've met the appropriate enrollment qualifications - or enrollment criteria.

But I'm in the global. It's Rodger.goodacre@cms.hhs.gov.

(Pam Switzer): And (Judy) I'll connect you (Judy), because I have your email too.

Roger Goodacre: Okay. That'll be great (Pam).

(Judy Cranford): I appreciate that. Thank you.

Operator: Our next question is from (Juanita Waters) from Colorado. Your line is open.

(Stephanie Stone): Hi. My name is actually (Stephanie Stone) from Colorado, Ute Mountain Health Clinic. I'm the chief pharmacist.

A question to the second speaker, she talked about the Medicare Plan Finder. Is that under the medicare.com site or medicare.gov Web site?

(Juliet Turae): Exactly. You would just go to www.medicare.gov and then click on the first link, first main link in the center of the page. It should say, Medicare Prescription Drug Plan and then 2009 data, or something like that.

(Stephanie Stone): Okay. That's excellent. Thanks. Also, is this a recorded session?

Natalie Highsmith: Yes it is. It will be posted on the Special Open Door Forum Web page beginning November 13th and it will be available for 30 days.

(Stephanie Stone): Okay. and then the third question, so on the Part D vaccine, if they are administered by the public health nurse and she is a 638 employee and not an IHS employee, does anyone know if those can still be billed?

(Pam Switzer): I do know that they can be billed. They can be just billed via Part - I'd have to look this up. They can just be billed like they would normally be billed, Part B, you know, in the Part B.

(Stephanie Stone): Right. Well, it was our understanding that PHN administers the majority of the flu vaccine. She - and she's not part of our IHS clinic. We are not a 638 site, so we have not billed for the flu vaccine in spite of the clinic, because it was administered by a 638 nurse.

(Pam Switzer): And that's fine, because part influenza vaccine and pneumococal are both Part B, like in boy drugs. They're not Part D drugs.

(Stephanie Stone): Okay, so I was kind of flipping through that. I have the page up here. It didn't actually state on here what the Part D, D as in dog, immunizations were, so you had to go the Plan Finder for that.

So you know that influenza and pneumococal are B as in boy drugs?

(Pam Switzer): That's correct. And I actually have a list. I didn't send it out yet, 'cause I'll wait for the instructions. It'll go with the instructions of all the Part D vaccines.

(Stephanie Stone): Okay. That's great. Thank you.

(Elmer Brewster): Rodger this is (Elmer). I'm going to need to sign off, so if anyone has a question for me, could you just email it to me via IHS?

Rodger Goodacre: We certainly well, (Elmer) and thank you for your participation today.

(Elmer Brewster): Thank you very much. Bye.

Natalie Highsmith: Okay (Cindy) we're ready for our next question please.

Operator: Yes. Our next question is from (Colleen Shimoni) from New Mexico. Your line is open.

(Colleen Shimoni): This question was for (Elmer) but I guess I'll email him.

Rodger Goodacre: Thank you.

Operator: Our next question is from (Sherry Ladesma) from Nevada. Your line is open.

(Sherry Ladesma): Hi. I had two questions. When you mentioned the draft about the creditable coverage, the part about the new beneficiaries and then the three thing on sending out another notice.

That software that you're working on, is that something that's going to come up on a patch in IHS or is that something that is totally separate? Is that for tribal or is that for HIS or is it going to be designed for both and when?

(Pam Switzer): You're talking about the patch that does the letter?

(Sherry Ladesma): It's - you were saying it's about the creditable coverage in a draft for next year.

(Pam Switzer): Oh yeah. The draft means just that -what the process is going to be and sort of outlining you know, what the process will be for next year, and so that we can, you know, kind of get everybody to - whatever the requirements are going to be, how we're going to go ahead and do this.

So, as far as like doing the software for the letter, I thought the software - there's already software that's available that you load in that automatically does the mail merge and all of that.

I know - I have a copy of it all and instructions on how to use it all. I just assumed it was distributed nationwide already.

(Sherry Ladesma): It is. It's just that you're designing a new one for the next year right, is that what is?

(Pam Switzer): It's actually not going to be probably a new one so much, as the ability to be able to - it's in the adjustments, it'll be really minor to be able to pull something up and print it out on demand. Is that what you're talking about?

(Sherry Ladesma): Yeah.

(Pam Switzer): So print it up. You want to - they'll have to probably be making adjustments to that. You're correct on that.

(Sherry Ladesma): Okay.

(Pam Switzer): To make it easy for a facility to be able to print off a letter, if a patient wants one.

(Sherry Ladesma): Okay. So we'd have to work with that in addition just tracking our own system, you know, like for the three letter or something versus our new one in?

(Pam Switzer): And it won't be three years, it'll be just one year now.

(Sherry Ladesma): Okay. All right. And then the other thing I wanted to - I received a copy of that memo on October 22nd one and it gives the break-down of the resource and the mix and stuff, so I can kind of presumptive eligibility towards the extra help program.

But the way I'm reading this, is that we still have to watch and track those, because if they do become eligible for the extra help, that CMS is going to automatically enroll them in a plan, whereas in Nevada, we've only got one option.

I'd still have to work with that to try to get it changed over, is that correct? 'Cause that's kind of how I'm reading this information, is that they're going to automatically do it still.

(Pam Switzer): They will be automatically enrolled in a plan, if they're not already in a plan and they haven't opted out of enrollment.

(Sherry Ladesma): Yeah. I'm looking at like some of the more newer ones that I will be putting the extra help applications in for, and what I've noticed the pattern to be, is they're automatically enrolling into something where I have to cancel it out, then redo it if they're opting to pick the one up that we have, which is going to be First Health this year.

So I'd have to still continue that pattern, correct?

(Pam Switzer): Yes, yes.

(Sherry Ladesma): Okay. Okay. But thank you for the eligibility information. That helps a lot.

(Pam Switzer): Good.

(Sherry Ladesma): Thank you.

Operator: Your next question is from (Ellen Digsom) from Montana. Your line is open.

(Ellen Digsam): Yes, I just needed the link to that Web site, so can I just give you my email address?

(Pam Switzer): Yes, you can. I'm ready.

(Ellen Digsam): Okay. e_Digsam@thhs.cskt.org.

(Pam Switzer): Okay. What was the first letter of it?

(Ellen Digsam): E as in Ellen.

(Pam Switzer): Okay. Got it. Okay.

(Ellen Digsam): Thank you.

(Pam Switzer): All right. Very good. Thanks.

Operator: Your next question is from (Johannes Spang) from Montana. Your line is open.

(Johannes Spang): Yes, I also needed the Web site if you could send it to me too?

(Pam Switzer): Okay, sir are you on a lister on the point of sale.gov? Yeah the point of sale lister?

(Johannes Spang): I don’t see think so.

(Pam Switzer): Okay. What is your email? Sorry, I don’t know how - you know, the other thing I can do is, and I can ask CMS, Rodger and folks if I can just send it out. Can you send it out to the same group and I’ll just do that, both the instructions to the lister and the link, so everybody can have it?

Rodger Goodacre: Sure. What we can do, (Pam), if you send it to me, we’ll send it out to everybody that - we’ll send that information out to everybody that we notified about the call.

(Pam Switzer): Yeah, is that okay with you to do it that way?

(Johannes Spang): Yes.

(Pam Switzer): I’ll do that. That’s what I’ll do, ‘cause...

Rodger Goodacre: Okay. Well we’ll - if we can do that (Pam), we’ll do that everybody.

(Pam Switzer): Okay.

Rodger Goodacre: Just send it to me (Pam) and we’ll move forward with that.

(Pam Switzer): All right. I’ll do that now.

(Johannes Spang): All right. Thanks.

Operator: Our final question is from (Laura Cluver) from Washington. Your line is open.

(Laura Cluver): I have a question for (Pam). On these agreements with IHS, do they ever expire or is it a continual basis that we renew them?

(Pam Switzer): What has happened, what I've noticed, this is just more of an observation, is that like on the commercial side they never seem to - they never seem to expire. They continued on.

When they seem to change is when like a company buys out another company, for instance. You'll see Caremark since they just purchased Long's RX America, we may not see anything and then maybe somewhere in the middle of the year or next year, we're going to see a new agreement.

So we're - even the commercials will have to redo again. For Medicare Part D what we've noticed is there is continually tweaking to the plans and just how they're doing. I think they're being reviewed by CMS. So a lot of the changes are just minor changes.

So it's not they're so much renewed, is just they're modified is I guess, is why I'm doing it. So it's not like they end, it's more that they have to get updated with new information and resigned. That's what I've noticed.

(Laura Cluver): And I do have another question for you, is with these new plans that are coming in, would there be a format in point of sale, will they put a patch in before the first of the year?

(Pam Switzer): Yeah. That was a good question, you know, and I forgot to say that. What I had meant, I wrote it down and I forgot to even say it. Those of you that are familiar with point of sales know that there's usually, I call it a cheat sheet, and what is it lists the column with all the plans,

the name of the insurer, which is B-the name of the plan, the name of the point of sale format that it should be linked to, and the bin and the PCN and any of that, that type of information.

And until - we're still waiting to hear on a couple of them what the new bins and the PCN's are going to be. And hopefully, we'll have all that - I called yesterday to see if I can get some of that, especially for some of the new ones, but they don't have that put together yet.

So we'll check here in a couple of weeks and see if they have that and then we'll update that list and send that out, including the - for the new plans, the new federal tax Id number and everything, so you can just input all it in and be ready to go.

(Laura Cluver): Okay. Thank you very much.

Operator: We did have a few more questions come in the queue. The next one is from (Colleen Shimoni) from New Mexico. Your line is open.

(Colleen Shimoni): This question is for (Pam). My name is (Colleen Shimoni). I'm calling from Zuni IHS. Do you have a current updated list of all the Part D plans that have an IHS contract?

(Pam Switzer): Yes we do. Let me see. Probably the easiest thing to do would be to - when I send it - what I'll do is I'll include in that folder when - that I send to Rodger that's going to send out and everybody on the ftp site. I don't have it up in that folder now, but we'll go ahead and include it in there.

What it'll do, is it'll list the ones that are currently - they're in place, and then the ones that are just - that we're working on in 2009. And

then what you should know, though is that we're going to have all of them by middle of December, we'll have all of them. So 2009, all of the LIS plans, we'll for sure have those.

(Colleen Shimoni): Okay, (Adam) had mentioned at our last round meeting that we were already contracted with Sierra RX. Is that true?

(Pam Switzer): Yes, that's correct. You already are.

(Colleen Shimoni): Okay. Thank you.

Operator: Our next question is from (Georgia Harvey) from Arizona. You line is open.

(Georgia Harvey): I just have a question about the dual eligible. Are we also changing their health plans if they're on Humana, if they are in the nursing care facilities?

(Pam Switzer): Individuals in long term care facilities do have an opportunity to switch plans any month, if that's necessary. And that doesn't - they don't have to be qualified for the extra help to have that special opportunity. It's just a function of the fact that they are in long term care facilities.

So for instance, if they enter a facility and the administration of that facility wants them to be in a particular plan, they can switch.

(Georgia Harvey): Okay. And also can we have that Web site also, that ftp?

(Pam Switzer): Yeah, we're going to send that out to everybody. If you received the email on this call, you'll get it again.

(Georgia Harvey): All right. Thank you.

Rodger Goodacre: We'll do that and also Natalie...

Natalie Highsmith: We're going to - this will be posted on the special Open Door Forum Web Page under the related links outside CMS.

(Georgia Harvey): Oh, okay.

Natalie Highsmith: It will be posted there. What's today? Wednesday?

Rodger Goodacre: Today would be Wednesday.

Natalie Highsmith: It should be up no later then Friday, this coming Friday, the 7th.

Rodger Goodacre: And we'll also move forward to email it to our list too.

Natalie Highsmith: Yeah, what I was going to just say, for those of you that, I know you mentioned (Adam) you can just let him know if there's any area people on there. I'm already scheduled to do a few of the site area only, just 'cause we kind of focus on the plans in your area, if you wanted to do that a Web Ex.

And it's easier to see, 'cause then I can have the plans all up in front of us.

Operator: Our next question is from (Jerry Taylor) from Arizona. Your line is open.

(Jerry Taylor): I just wanted you to know (Pam) I send all that stuff.

(Pam Switzer): Okay, thanks.

Operator: Our next question is from (Rachel Allen) from Arizona. Your line is open.

(Rachel Allen): Good afternoon. My name is (Rachel Allen). I'm calling from Four Corners Regional Health Center. Good morning (Pam).

I have the Web site, but I'm unable to open that ftp and also can you please put us - put me on your list for all those IHS contracts and stuff?

(Pam Switzer): Okay, very good (Rachel). I will do that.

(Rachel Allen): Okay. Thank you.

Operator: And our final question is from (Juanita Woodes) from Colorado. Your line is open.

(Stephanie Stone): Hi this is for (Pam). This is (Stephanie Stone) Colorado, Ute Mountain Health Clinic.

(Pam) do you know where they're at now as far as IT on doing the split bills or the coordination of benefits? There are a number of drugs, especially the (Benzodiazepine) clasp that does have to be split billed in order to get reimbursement and our system's not capable of doing that at present time?

(Pam Switzer): I don't know if (Chris Kirk) is there. I'm not sure where they are on that design of that piece of it, but I will tell you, I have instructions

because in Arizona and Oklahoma and some of the other states, they can do this, if it is a rejection by Part D.

So let's say a Part D rejects, like a (Benzodiazepine) or some of the OTC's that are - and the state Medicaid will pay for them, then I have been directed - if it's a pure rejection, then I have instructions for how to override that and we can get that paid, 'cause we can do that here in Arizona. They can do it Okla- there's several states that do that, that will provide that extra coverage.

The problem that they have in the design, is when part of it's been paid and then the coordination draft is the second piece. In other words, there's already been a payment received for one - for the plan, and then billing the second plan for the balance. That's the software problem.

But if it's straight out rejected, and then it's just you're going to a different plan, we can do that. Is that what your situation is?

(Stephanie Stone): Well, not exactly. I mean, we have like our (Arena Vites) which are vitamins for our dialysis patients. Those are a straight out reject and I can turn around and put Medicaid as the primary payer and it will go to Medicaid and Medicaid will pay.

But with the (Benzodiazepine)'s and we dispense a lot of quantities of them for the same population, the dialysis patient, it still rejects it through Medicaid when I do that.

And I called Medicaid and Medicaid said that we have to have the denial in there from Medicare.

(Pam Switzer): If we have the - that's the instructions I can have to get through there. Because there's a code you need to put in there.

So...

(Stephanie Stone): Yeah, let's have a...

(Pam Switzer): Yeah, there's a way to do that. That's what we've been - you have to put a code in to be able to do. So I have those instructions. I don't what they are for Colorado, but it's all - it's been all the same across in all the states to what cover.

(Stephanie Stone): Can you send that to me?

(Pam Switzer): Sure.

Natalie Highsmith: She's not in the queue?

Operator: We're showing no further questions in queue at this time, ma'am.

Natalie Highsmith: Okay, I'll turn the cover over to Rodger for closing remarks.

Rodger Goodacre: Well, I'd like to thank everybody- personally I'd like to thank all of our presenters for sharing all that valuable information with us today. And I'd like cheer - and I like, of course, to thank all of our participants for their time and attention to this and your helpful and useful questions that we've been able to share with everybody.

I will forward the information out that (Pam) will be sending us about that Web site, along with some other general information that we have

and Natalie will be posting that on the Open Door Forum Web site on the related link section issue, as she so noted.

We look forward to a successful working with you to do successful open season this year and in enrolling everyone in the appropriate programs. We stand ready to help. We'll continue to work with IHS and we can have further calls or other activities as necessary.

So again, I'd like to thank everybody very much for all their help and work on this.

Natalie Highsmith: Thank you everyone. (Cindy) can you tell us how many people joined us on the phone?

Operator: It looks at highest count we had 170.

Natalie Highsmith: Okay. Wonderful. Thank you everyone.

Operator: Thank you. This concludes today's CMS conference call. You may now disconnect.

END