

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Medicare Enrollment Assistance Demonstration Project
Wednesday, October 28, 2009
2:00 – 3:30 P.M. ET
Conference Call Only

On October 28, the Centers for Medicare & Medicaid Services (CMS) is holding a Special Open Door Forum (ODF) in order to solicit stakeholder input for the design and development of a proposed Medicare Enrollment Assistance Demonstration Project. This Special ODF will primarily be a listening session for CMS to gather information from stakeholders about issues that will affect the demonstration design and implementation. This demonstration is authorized by Section 4018 of Public Law 105-33 (The Balanced Budget Act of 1997) for the purpose of evaluating the use of a third-party contractor to conduct Medicare Advantage plan enrollment and disenrollment functions.

CMS believes that the Medicare Part C and D programs have clearly improved access to health care and prescription drug services for millions of elderly and disabled Americans and have offered Medicare beneficiaries a wide range of plans from which to choose. At the same time, research suggests that significant numbers of beneficiaries are confused by the array of choices and find it difficult to make enrollment decisions that are best for them. Thus, CMS intends to explore all available options for providing Medicare beneficiaries with comprehensive information and assistance services to assist with their health coverage decision-making and enrollment. The effectiveness of the project could be measured by any one or a combination of the following: decreased instances of complaints about marketing and enrollment problems, increased enrollment in limited income programs, increased beneficiary understanding of their coverage options, and greater beneficiary satisfaction with their coverage choices.

CMS anticipates that the enrollment assistance contractor will coordinate with currently existing sources of information and assistance to beneficiaries, including: the State Health Insurance Assistance Programs (SHIPs), 1-800-MEDICARE, community-based partners, CMS publications, the www.medicare.gov web site, plans, providers, and other sources of information. Unlike most of these information sources, we envision that an enrollment assistance contractor would also be expected to conduct direct outreach to specifically targeted beneficiaries who are contemplating coverage decisions. For example, the enrollment assistance contractor in the demonstration could focus on helping beneficiaries who are new to Medicare to understand and analyze the various coverage options and decisions they face as new beneficiaries.

Again, CMS is holding this Special ODF to gather input to assist us in the design and implementation of the proposed demonstration. Thus, although all comments and suggestions are welcome, we will not be able to respond directly to comments at this Forum. Instead, we intend to consider carefully the information we obtain as we proceed with the development and implementation of the demonstration.

CMS is especially interested in information and feedback in the following topic areas:

1. Enrollment Assistance Functions

CMS envisions that the Medicare Enrollment Assistance Demonstration will be designed to provide unbiased information and assistance to beneficiaries to help them learn about and evaluate their coverage options, including: Original Medicare, Medicare Advantage, Medicare Part D Prescription

Drug Coverage, Medicare supplemental insurance coverage (Medigap), and employer coverage. Possible functions of the contracted entity include:

- Operating a call center with representatives specifically trained to provide one-on-one assistance to beneficiaries to help them understand their coverage options and enroll in plans;
- Conducting direct mail and telephone outreach to targeted beneficiaries (such as beneficiaries new to Medicare) to offer assistance in evaluating coverage options;
- Conducting direct mail campaigns to Medicare beneficiaries to inform them of coverage options and enrollment periods;
- Conducting community outreach and education activities focused on coverage options;
- Sub-contracting with community-based organizations to expand outreach efforts and reach targeted populations;
- Establishing community-based enrollment centers;
- Processing enrollment applications received from beneficiaries and submitting enrollment requests to plans.

CMS seeks input on the potential functions that the contracted entity in this demonstration project may perform to effectively inform beneficiaries of their coverage options. CMS seeks specific comment on the potential functions under consideration (as listed above) as well as recommendations for additional functions that should be considered.

2. Plan Marketing Activities in Demonstration Site

CMS is seeking comment on the extent of marketing that it should allow Medicare Advantage or Part D plans to perform in the Medicare Enrollment Assistance Demonstration site(s). We recognize that many states have utilized contractors to serve as Medicaid enrollment brokers to facilitate Medicaid managed care enrollment. Assorted rules and limitations have been applied to plan marketing and enrollment in different states. With the additional information about coverage options to be supplied by the enrollment assistance contractor in the demonstration, CMS is seeking comment about the appropriateness of such marketing limitations upon Medicare Advantage or Part D plans as part of the demonstration.

- a. What limitations on plan marketing and enrollment activities are appropriate, given the potential role of an enrollment assistance contractor to conduct direct beneficiary education and assistance in choosing among coverage options?
- b. Have the collective experiences of Medicaid beneficiaries, states, plans, and contracted Medicaid brokers demonstrated models for the interaction between plan marketing activities and enrollment assistance activities that have proven successful in educating beneficiaries about their options in the Medicaid managed care market?
- c. What are the minimum amounts of plan marketing and enrollment activities necessary to assure that beneficiaries are aware of their coverage options, and to foster plan competition?

3. Demonstration Implementation Strategy

CMS is seeking input on the implementation strategy of the demonstration project, including but not limited to the following issues:

- a. What specific beneficiary populations are most in need of Medicare-contracted assistance service in helping beneficiaries evaluate their coverage options? Should CMS consider initially providing enrollment assistance services to a selected target audience of beneficiaries in the demonstration site(s), such as beneficiaries who are new to Medicare?
- b. If CMS initially provides enrollment assistance to a selected target audience, should CMS design the demonstration to incrementally expand the project to additional target populations or the entire beneficiary population in the demonstration area over the three-year term of the demonstration?
- c. How long would it take for an enrollment assistance contractor to become operational following contract award?
- d. How should the enrollment assistance contractor interface with other providers of enrollment assistance such as State Health Insurance Assistance Programs (SHIPs), area Agencies on Aging, and Medicare Advantage and Part D plans?

4. Demonstration Site Selection

Assuming that the demonstration locations encompass 1-2 states, CMS is seeking input on the state selection criteria. Two potential criteria for identifying potential states that are under consideration are the presence of significant Medicare Advantage market penetration and high levels of complaint rates related to the marketing of Medicare Advantage plans. CMS is seeking specific comment on the potential use of these criteria.

- a. Are these criteria generally appropriate, and what other selection criteria should CMS consider when choosing 1-2 states as demonstration site(s)?
- b. MA Penetration: Should CMS choose a site(s) from among states that have a current rate of enrollment in Medicare Advantage that is greater than 10% of the eligible beneficiaries, testing the concept in a more developed Medicare Advantage market?
- c. Complaint Rates: In part, the demonstration project will test how well the use of a Medicare-contracted enrollment assistance entity may reduce the challenges that some beneficiaries encounter in evaluating and enrolling in Medicare Advantage plans. Should CMS choose a site(s) from among states where there is currently a higher rate of enrollment and marketing misrepresentation complaints filed against Medicare Advantage plans by beneficiaries? Are there other valid measures of marketing problems?

5. Enrollment Assistance Contractors

CMS anticipates that this demonstration project will require a contractor that can provide a high-capacity call center staffed with well-trained professionals with multilingual capability, a publication development and distribution capability, a mail house for conducting direct-mail campaigns, data management capacity, and the demonstrated ability to foster positive relationships with community-based organizations that also work to serve and inform Medicare beneficiaries. CMS is looking at the strategies that states have used in their acquisition of Medicaid enrollment assistance contractors as potential models for its acquisition strategy.

CMS seeks input on the potential entities that could contract to provide enrollment assistance services in this demonstration project. CMS specifically requests input on the following:

- a. What are the selection criteria that CMS should consider using as part of its acquisition strategy for a contracted enrollment assistance provider?
- b. What performance standards should CMS consider using to monitor the performance and evaluate the effectiveness of a contracted enrollment assistance provider?

How to Participate

CMS requests that interested parties prepare their comments or input in written form and submit this information before the Special ODF to MedicareEnrollmentDemo@cms.hhs.gov. At the Special Open Door Forum itself, we encourage all interested parties who wish to present their positions or comments to limit their oral presentation to approximately 2 minutes to highlight the information submitted in your written comments.

We look forward to your participation.

Special Open Door Forum Participation Instructions:

Dial: 1-800-837-1935

Reference Conference ID#: 36166283

Note: TTY Communications Relay Services are available for the Hearing Impaired.

For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will A Relay Communications Assistant will help.

An audio recording and transcript of this Special Open Door Forum will be posted to the Special Open Door Forum website: http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning Monday, November 9, 2009 and will be available for 30days.

For more information as this project proceeds, please see the demonstration website:

<http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/> and select "Medicare Enrollment Demonstration".

We will be updating this site regularly.

For automatic emails of Open Door Forum schedule updates, emailing 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.

Audio file for this transcript: <http://media.cms.hhs.gov/audio/MediEnrollAssistDemo102809.mp3>

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Medicare Enrollment Assistance Demonstration Project
Moderator: Susie Butler
October 28, 2009
2:00 pm ET

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

At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Medicare Enrollment Assistance Demonstration Project Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Susie Butler, you may begin your conference.

Susie Butler: Thanks so much, Sarah. And I'd like to welcome everyone and thank you for taking the time to attend and share your thoughts today about the demonstration project idea. This is a little bit different format for the Open Door Forum. We are going to be presenting some ideas, but mostly listening to your ideas and comments and we'll be interjecting. It will be more interactive than some of the Open Doors we've had in the past because we're probing you to hear what you have to say.

We'll have some brief opening remarks from Tony Culotta, the Director of the Medicare Enrollment and Appeals Group. Then we'll go through the five

areas that we outlined in the call announcement, giving you a chance to weigh in with your thoughts and ideas. We just ask that you keep your remarks brief so that we can be sure to give time to others. We'll monitor the number of participants who's queued up to ask questions and limit your time if we need to. I'm sure you'll understand that we want to get to everyone who has something to say today.

Now, as Sarah told you in the queue up to today's call, if you have a question or have a remark, please use star-1 to get yourself in the queue to ask that question.

Now, let's hear from Tony.

Anthony Culotta: Thanks, Susie. Thanks for calling in. I appreciate people who have already sent in comments on the announcement that we sent out. Just before we go to substantive remarks, I just want to let you know that we'll probably have a little bit more of a free-willing structure that might have been anticipated based on the announcement.

We've already gotten about a dozen comments, there are probably 100 people on the call. So, you know, we're not just going to limit it to people making statements and things like that. What I really want to accomplish here today is the dialogue and the way I want to do that is after I get finished making a few remarks, I'll turn it over to Kevin Simpson and we'll try to focus on the specific areas that we put out in the announcement and get your thoughts on those.

At the end of that process, assuming - I think we'll still have some time left and we'll try to make sure that we do, and then if people want to make some, you know, general remarks or bring up points that weren't addressed earlier, we'll allow some time for that.

Okay, so basically as you saw in the announcement, we're clearing all our available options for providing Medicare beneficiaries with comprehensive information and assistance services for purposes of their healthcare coverage decision making enrollment.

Obviously right now we have a market that has a lot of good options for beneficiaries, emphasis is on the many options. And while we've improved access to healthcare and prescription drug services through the Part C and D program, at the same time, there have obviously been lots of people that believe that the choices can be confusing, and also that there have been - you have to admit that there have been some marketing issues that we've dealt with through plans and through our complaint process.

So I don't see things getting simpler going forward, so that's why we're embarking on this. We already have a lot of existing resources to help beneficiaries understand the decisions and help them make choices, including the SHIPs, 1-800-MEDICARE, other community-based partners, our Medicare.gov framework. But there are some differences in what we're looking at here than some of the existing sources of information and one big one would be under any kind of demonstration we'd be looking at outreach to individuals rather than just responding to individuals that come to you.

Another one is now would be - I mean, talking about individual outreach, another thing that the demonstration would permit would be to change some of the rules that apply to plans in a given area in terms of marketing which is something that's now on the table and we're going to talk about today.

And for example, right now under 1-800-MEDICARE, another thing is they don't ever tell a person, you know, "Here's what I think you should do," or make a suggestion where I think if we had under demonstration project, you

know, that would be an expected thing that a person would get which is, “Here’s the best thing for you.”

So, I think that pretty much lays out, you know, why we’re moving forward with this. I think I’ll also mention that particularly sorts of beneficiaries who might be better served and - by somebody new than what we’ve got going on today. For example, low income beneficiaries or people who have - don’t speak English and these are areas where right now I think that there have been suggestions that we don’t do the best job on where there’s room for improvement.

So simply stated, we believe there are opportunities for us to improve our information services, beneficiaries, to support them making their coverage decision and that’s the goal of the project, to try to find improved ways to helping beneficiaries by experimenting with some innovative approaches. Possibly drawing on things that have already happened, you know, in the Medicaid world to help people understand their options and make the best possible coverage decision.

So over the next 60 or 90 minutes and going forward, we’re looking forward to hearing from you about some specific topics that we’ve raised such as which beneficiaries are most in need of additional help, what kind of services might be the most helpful to them, where would be the opportune places to conduct this demonstration. I mean, obviously do you throw it to a market like Florida. It would be a lot different than putting it in Vermont, okay? You know, the kind of questions we want to raise.

Whether or not there should be any special limits on plan marketing or enrollment functions in the demonstration site and how we should work with other organizations for help in developing and administering this project. And we’re definitely in the formative stages of the project. We’ve done a lot of

work here to sync through what are some viable options, but there hasn't been any decisions made and even the decision as to whether or not to go forward with the project is not set in stone.

What will happen after this is we'll go back, we'll think about things that have been said today and the written comments that have been submitted. We'll write a proposal and run it up through senior leadership here and decide whether or not to go forward and, you know, what would be the parameters of the project and when it would start and things like that.

So I know people - some people have already submitted comments. I want to encourage them to continue - the rest of you to continue to work on those kinds of comments if you have them. We'll be taking notes today and we'll be listening carefully what you have to say but it wouldn't hurt to put it in writing.

I would ask you to try to do that within the next week to ten days in the group, actually, naming November 6 as the date. It's not like anything that is ever going to be disregarded but in order to move forward, you know, there's contracting, there's lot of project development that has to happen. So if we want to get this done, you know, some time in the end of 2010, 2011 timeframe that I have to start now so I can't just wait indefinitely for, you know, comments.

I think it's about all I need to say at this point. I'm sure you'll be hearing from me more later on the call. And with that, I'm going to turn the call over to Kevin who can lead us through the specific questions that we post in the call announcement.

Kevin Simpson: Thanks, Tony. Thanks everybody for joining us today. As Tony mentioned, we're going to try to go through our discussion today on the five topical areas

that were identified in the announcement. Obviously some of these questions one part of it relates to another and so we don't expect folks to strictly adhere each area but we do actually try to focus your comments in each section on that particular topical area.

The project team here has identified these as five of the critical decision points that we need to make as we look at this project. And so I just want to make sure everybody has the chance to focus on each one those five and certainly we encourage you to - at each opportunity if you have something to say about all five, then by all means we welcome you to do that as each one of the discussion topics open.

So the first one is on the enrollment assistance functions. You know, we're talking about here, as Tony mentioned, designed to help people make more informed decisions, decisions that they're happy with, decisions that make rational, economic sense for them.

And so the question is, "So what do we do?" We've laid out some of our brainstorming ideas in the bullet points in the announcement, everything from a call center that might do one-on-one outreach calls, outbound calls, mail center operations, working with SHIPs and other community-based resources on community education efforts designed perhaps to targeted population. These are some of the things that we have thought about here.

And so at this time, I'd like for folks to cue in and share with us your thoughts and ideas about this area. One thing that I'll try to remind yourselves here at CMS and also remind you, this is a reverse of the normal Q&A on the phone call we have with CMS. Normally it's the folks on the phone asking questions and us trying to provide some answers.

We are not here to provide answers today. We are here to ask questions and we ask you to provide us with information and answers. This - we have not put the stake on the ground of this project in any way to be able to answer questions about it. So don't be surprised if you ask me a question that I will then respond with a question.

So thank you very much and some have queued up and we're going to get started.

Sarah?

Susie Butler: Sarah, if you can open the lines for questions and folks if you could queue the star-1 to get your questions or comments in to the queue.

Operator: At this time, I'd like to remind everyone, in order to ask a question, please press star then the number 1 on your telephone keypad.

And your first question comes from the line of Bill Vaughn from the District of Columbia. Your line is open.

Bill Vaughn: Well, hi. Thank you. Bill Vaughn with Consumers Union. And we're just hoping that in the one-on-one counseling which we hope there'd be a lot of, that you could make recommendations and warn people to look at the total cost of plan and not just what the lowest premium is. We've been working with - Best Nation Rx has done some work for us which shows that 92,000 seniors in Part D save about \$33 million a year by looking at the total cost entering their drugs that they actually use as compared to if they just went with the lowest premium.

And we think when you look at the Medigap variations that are on your Web site, a lot of them vary by 500%. You type in five common drugs on Part D

and look at variation in different states and the plans vary by \$2200, \$2400 on these five common drugs that we've been using.

So stressing to people look at the total cost, let us help you with how you can enter the drugs and get an estimate on total cost would be an enormous savings and really, really fulfill the promise of Part D. And that's about it. Thank you very much.

Anthony Culotta: Bill, this is Tony Culotta. I just wanted to say that, you know, I'm familiar with your study and I think, you know, very to the point and actually sort of obliquely referring to it in the announcement here. So I think that would definitely be an element of any kind of project.

Not that we're going to give answers as Kevin said but I think that one, you know, pretty clear cut that you have to look at them.

Bill Vaughn: Well, that'd be awesome. It would be a wonderful help for people, particularly the low COLA year.

Anthony Culotta: Yeah, okay, thanks.

Bill Vaughn: Thank you.

Operator: Your next question comes from the line of Ginger Zielinskie from Pennsylvania. Your line is open.

Ginger Zielinskie: Hi there. First of all, I just want to say thank you so much for providing this forum in which to comment. I think it's wonderful for all of us in the field. I'd like to comment specifically on outreach, education and enrollment. We conduct outreach and enrollment services for public benefits. To date we've

helped about 165,000 older American sign up for benefits they're eligible to receive.

In addition, in the open enrollment season in 2007 and 2008, we opened another organization. It was an insurance brokerage organization. We wanted it to be not-for-profit with the goal to educate individuals on all of their Medicare options and to provide objective advice and support in enrolling in that plan.

Some key points that we found through that experience was first of all, the information is so extremely challenging. We're in Pennsylvania and it was divided by county. So in able to counsel, to truly counsel and educate them on their choices was really challenging to decide for all of that information.

Secondly, as you mentioned in your statement, targeting is successful, especially our work with Benefits Data Trust. We've been very successful in using these strategies to hone in individual very likely eligible, specifically the low income population.

Thirdly, I think having someone that can develop that trust and rapport for someone to be able to talk about their Medicare choices is really essential. We - again, we had a lot more experience and we're able to help someone apply for the low income subsidy and then talk to them about their - all of their Medicare options.

Many times people were in the wrong plan but were too afraid to change and so having that trusted person to be able to help them look at their different options really was very important when they were making that - those choices.

I did submit comments electronically, so I expanded on them and more, but overall, we do believe that direct mail and telephone outreach and education is

doable. It does need to come from a trusted source and does need to be targeted.

Anthony Culotta: Thanks. I know we got your comments and appreciate that.

Ginger Zielinskie: Great. Thank you so much.

Operator: Your next question comes from the line of Paul Precht from the District of Columbia. Your line is open.

Paul Precht: Hi. This is Paul from the Medicare Rights Center. I think one of the capabilities should be besides providing enrollment assistance in drug plan or an MA plan or Medigap plan, also helping people would navigate the - or - and apply for the low income subsidy over the Medicare savings programs.

And that often there maybe additional functions that the enrollment centers will be asked to perform by the beneficiaries that contact them and these could range from, you know, case work issues, problems with enrollment or disenrollment or even Part D appeals, some of these may. So I would like you all to be open sort of expanding what they could do. But I think if it's viewed that some of these functions are beyond the scope of the project, I think it's important that the enrollment centers have connections with SHIPs or community-based organizations or others that can handle these more complicated cases so that people aren't just said - told, you know, you have to call a different basically.

Anthony Culotta: Thanks, Paul. This is Tony again. I mean, we're definitely thinking along those lines as well and, you know, I think one of the great things about a demonstration is you can sort of how that - you know, what kind of satisfaction rate you might have by doing it that way compared with the way we do things now in terms of some those that you mentioned.

Paul Precht: Okay, thanks.

Operator: Your next question comes from the line of Wendy Richey from Tennessee. Your line is open.

Wendy Richey: Hi. This is Wendy Richey and just a couple of things I wanted to point out that we experience today. If we want to try to go towards these resources to provide beneficiaries with educated decisions then we definitely need to focus when maybe consistent needs assessments that need to be done for all beneficiaries across the board because what we do experience today and I won't say from what venue, there seems to be a disparity in knowledge.

So the guidance that's provided to beneficiaries today on the different plan options out there may not necessarily be correct. An example is - some examples that we see are beneficiaries are steered to a specific special needs plan that maybe they're not eligible for the special needs plan so it's really a disadvantage to the (bene).

So my point is that a consistent needs assessment is definitely a must that should be considered that all venues would have to use because if you have a disconnect with the training, then there is going to be inconsistent education to beneficiaries.

Kevin Simpson: Wendy, this is Kevin. In talking about needs assessment, can you go further - are you talking about purely from a medical perspective? Are you looking at that also from an economic perspective of the beneficiaries?

Wendy Richey: Overall picture, what every plan should be doing and I'm not saying they're doing it today. But they certainly should be - before anyone even starts getting into details about plans they offer, or plans a broker is representing, they

should be doing this needs assessment with the beneficiary to understand their doctors, their benefit needs, their medical - their situation that they have today that needs care, that would continue and not be disrupted.

You get into understanding their economics. You get into understanding the drugs they're on because ultimately the goal should always be, "Is this change better for the beneficiary? Should the beneficiary change? Should they stay where they are today?" It's an overall assessment and that should be done before anything moves forward.

Kevin Simpson: Okay, thank you.

Wendy Richey: You're welcome.

Operator: Your next question comes from the line of Georgia Burke from California. Your line is open.

Georgia Burke: Thanks. I'm calling from the National Senior Citizens Law Center. And I just wanted to follow up on some of Paul's comments and just emphasize the importance of the community based enrollment centers piece of whatever the demo would be that there are limits to what a call center can do, particularly with the hardest to reach populations like limited English proficient folks who many of them really need to be able to sit down and talk with somebody face to face.

And that I think is really important in designing the demo to make sure that when the demo is over that that SHIPs who are, you know, consistently underfunded and that the community based network ends up stronger at the end of the demo because they're always going to be the first line for a lot of these issues.

Kevin Simpson: And in talking about that, as you mentioned the SHIPs as part of that, do you have any suggestions in terms of if we were to incorporate that kind of a community-based assistance center as part of this demonstration? Would you be suggesting that we would do that in partnership with the SHIPs, kind of as a demonstration site for SHIPs to learn off of or something separate using other community organizations that may have populations that you're mentioning, folks with limited English proficiency.

Georgia Burke: Probably both. Some of the SHIPs do a very good job with limited proficient folks and have many people on their staff. Some probably have a more difficult time with it particularly because they're so volunteer based so it's sometimes hard to get the right mix of volunteers for the population that - these underserved populations.

But I think also, I mean, there are some community-based organizations that are not SHIPs but that have such deep ties to particularly ethnic communities that you'd have to be incorporating them as well as SHIPs. I would think you might want to - if you are talking later on about where to focus, like what states or whatever, and to - you could sort of put more into the SHIPs in those particular states and then get some best practices for other SHIPs; I don't know, something like that.

Susie Butler: Thanks.

Operator: Your next question comes from the line Mary Sullivan from Massachusetts. Your line is open.

Mary Sullivan: Hi. Thanks for taking my comment. We're here at the Massachusetts College of Pharmacy and Health Sciences running a toll-free help line doing the Medicare enrollment piece. And one of the comments and one of the things

that we find is that when you consider doing this, the call support should be very local.

What we find a lot with the calls coming in is that beneficiaries have difficulty maneuvering through the systems in trying to understand the national program versus our local programs like a local SPAP and how that all affects their outcome of getting their benefits. So especially with the Part D is what we work with in a large array; that's one of the important things that we find.

Also what we're seeing is that working with the providers, we are here at the School of Pharmacy. So we have a direct impact on the pharmacists here in our community as well working with the providers in the community and adding that outreach to those avenues and to another avenues that are not traditionally thought of as healthcare as well, including like food pantries, including nutrition sites, doing a lot of the community outreach areas like that. That's important.

Kevin Simpson: In being from Massachusetts, do you coordinate any of your efforts with the connector there and I'm just wondering if there maybe some lessons we can learn from that relationship.

Mary Sullivan: So we do work - we do a lot of referrals with the connector. Patients who aren't Medicaid beneficiaries are looking for, (unintelligible) where we screen them for all the different programs in our state. So we do work with referrals and work with the connector application process. But with the Medicare beneficiaries, we concentrate more on the Part D and the Medicare advantage plan.

Woman: We work with those folks who are moving from the connector program who are turning 65 and who are becoming Medicare eligible. So those folks would

give us a call or outreach, we would outreach to them to get them on a Medicare Part D plan or a Medicare Advantage program.

Kevin Simpson: All right. Thank you.

Mary Sullivan: I did submit written comments as well. I'm not sure that you received that.

Kevin Simpson: I saw those earlier today. Thank you.

Mary Sullivan: Okay, very good.

Operator: Your next question comes from the line of Elaine Eakin from California. Your line is open.

Elaine Eakin : Hi. I'm with California Health Advocates and I do want to thank CMS for this opportunity to learn more about this demonstration project and already have learned some new things apart from the announcement that went out. We did submit comments this morning and I'd like to follow up on a couple of previous comments on this call and also ask for clarification.

As we're using a SHIP as a demo we didn't know that that was a possibility and we would highly recommend that, enhancing the resources of the SHIP. Someone said earlier, I think it was Kevin, that this demonstration would place individual outbound call to beneficiaries and our concern is, you know, we've consistently told beneficiaries that CMS will never call you. So how do we kind of, you know, change gears with that.

And I also heard that the demonstration would be making recommendations or advising people on options and that would raise some liability issues. So can someone answer that, these concerns?

Anthony Culotta: Well, that is a legitimate point. This is Tony Culotta. I mean, we're well aware of being CMS has positioned that over the years. So I don't think it's because we've never done something that we're, you know, precluded from doing it. On the other hand, you know, there are serious concerns and that's, you know, why we're asking you what you think.

Yes, Kevin?

Kevin Simpson: Yeah. I know that - yeah, it is a question that the - one that - I don't think it's impossible to negotiate especially on the outbound call issue. In fact, we did about a year or so ago, CMS did an LIS outreach study where we engaged with the contractor to outbound calls and coordinate efforts with SHIPs on the ground and it took a lot of work.

It took work in terms of community education and so forth and coordinating with 1800-MEDICARE to beneficiaries to call to verify that it was legitimate outbound call and those sorts of things.

The way we've done it, you raised an excellent point that if we are doing, we need to make sure that we've got all the appropriate background works that we don't kind of fly the face of anti-fraud messages that are out there.

Anthony Culotta: Do you have some other point you wanted to make?

Elaine Eakin : Also about the liability issues, if the demonstration project is advising people on making recommendations about options.

Anthony Culotta: Such as?

Elaine Eakin : You know, for SHIP in California anyway. We emphasized that we're here to give objective information, that we're not here to tell you which plan to

choice. Is that - what I heard earlier is that this demonstration project would be doing that, telling them, "You know, join this plan."

Anthony Culotta: Well, I think that if - I mean, I have to tell you, I've already said that and I think it's a possibility with the recommendation. I mean, we're sort of working with the states and I'm not sure exactly what happens with, you know, state contractors now in the Medicaid world.

But the goal would be to get the person to make a choice but I don't know, I mean, I'm just trying to be frank. You know, at the end of the day to me if someone is like, "Well, what do you think might be best for me?" Maybe there's a fine line where, you know, you could say something a little bit more than I can't really make a recommendation.

Kevin Simpson: I think we heard Bill Vaughan at the lead talk about, say, a little bit more advanced work in terms of cost analysis and we heard Wendy talk about doing a needs assessment. So I think if you start to put things like a more comprehensive needs assessment, along with more sophisticated cost analysis, that may very well lead somebody to a clearer plan decision than simply to say, "Well, here's the top five-plan based on your predicted cost for the year."

Kevin Simpson: And maybe you could say, "If this is your major concern then this would be, you know, the plan that would best meet that concern," or something like that. So, I mean, I think it's something that's going to have to be, you know, carefully worded and carefully approached.

Elaine Eakin : Okay, thank you. And I just want to emphasize a previous comment, somebody said about using a SHIP as a demonstration and someone also mentioned beneficiaries going to a trusted source and I think SHIPs have done a lot of work establishing themselves as being objective and having the resources.

So, again, you know, they've already established themselves as a trusted partner in the community. So linking to that or using a SHIP as a demo would I think be very appropriate.

Anthony Culotta: I mean, the bottom line is going to be that, you know, this will be done by contract and by competitive award. So once we understand what the functions are, then the entities that best meet that function would be, you know, judged through the contract process. So it is a SHIP, a SHIP.

Thank you.

Elaine Eakin : Okay.

Operator: Your next question comes from the line of Lee Thompson from the District of Columbia. Your line is open.

Lee Thompson: Hi. Thank you. This is Lee Thompson from the Health Assistance Partnership. And a lot of what I wanted to say has been said. We do work with SHIPs across the country and really feel that they're on the best position to really provide the services that have been discussed as far as providing accurate and credible information but allows beneficiaries to make informed decisions based on their unique needs, if you will.

I really just want to make two additional points which is again, I don't think that this contractor should be able to make suggestions about which plans to enroll in and I don't think that they should be allowed to do any type of marketing.

And I don't know if we want to move away from the enrollment question which you posed earlier, Kevin, but I just think that has the potential to create

more issues. And CMS has done a really nice job of trying to addressing a lot of the marketing issues in the past year and I know it's been very much appreciated and there have been improvements so I wouldn't want to take a step back in that direction, if you will.

And then my last comment was just whatever role this contractor is asked to play, I just think that it's so important that it's very clear what their role is. I am concerned about the potential confusion among beneficiaries as to where to go to get this help. You know, there are going to be a lot of duplicate entities now, you know, SHIPs, other community-based organizations, 1800-MEDICARE, the plans, et cetera, et cetera.

So, I just think that whatever role this contractor has that it should be narrow and it needs to be very clear what that purpose is and I think that will help beneficiaries and help the existing entities that already perform these services at the local level.

Kevin Simpson: Thanks, Lee. It's Kevin. Yeah, I want to follow up on two of your points. One is the coordination issue and I think perhaps we can look to the aging network in the whole no wrong door type of alignment that they have in their program; no matter where you go you'll get to the right service. And I would certainly want to see us engage in a project here that is seamlessly coordinated with the many other resources that are out there so that there is really no wrong door for the beneficiary to go in and they work together and get folks really to the help that they need. So I think that's a very good point.

The marketing issue and I think we're going to take two more questions before we get to that one. I'm going to do a little lead in there because I can tell from the comments that perhaps we weren't as clear of what we were talking about there. So we'll try to clarify that a little bit as we lead into the marketing section. But, thank you very much, Lee.

Lee Thompson: Thank you.

Operator: Your next question comes from the line of Paul Cotton from the District of Columbia. Your line is open.

Paul Cotton: Hi. Thanks everybody. I think everything we were going to say has already been said very eloquently by folks on the phone, that this should be done by people who are trusted sources. And the SHIPs are the ideal people to do that; other community organizations that are known in the community because what works best is one-on-one counseling from entities that people know and trust. So I think you've got a lot of consensus here on moving forward.

Anthony Culotta: Thanks, Paul. We got your written comments as well.

Paul Cotton: Thanks, Tony.

Operator: Your next question comes from the line of Patricia Nemore from the District of Columbia. Your line is open.

Patricia Nemore: Thank you. This is Trish Nemore with the Center for Medicare Advocacy. I apologize if this was covered because I got on the call a couple of minutes late but I haven't heard since I have gotten on any discussion of the scope of assistance. And from the document that you sent out, there are some references to being an enrollment center for Medicare Advantage and PDPs and there are other references that suggest possibly a broader purpose.

If the purpose is more narrow focusing on Medicare Advantage and PDPs, that raises a big concern about the use of resources and putting more resources into focusing on private plans is something that the center would be very concerned about. Again, reiterating as Paul just said, many people have made

similar comments about the SHIPs' role and how the SHIPs are a very likely entity to do this kind of work and the SHIPs definitely see their focus as all the options available to someone entering the Medicare system, including other public plans as well as the private plans.

So it's hard to see added value of going somewhere outside of the existing networks rather than strengthening the existing networks and I'm also concerned if there is a new entity especially taking enrollment into private plans that that creates another layer where possible errors can be made in data exchanges.

We are very involved with - we have some conversations going on right now about the difficulty of data exchanges, our D plans, as well as just simply enrolling into Medicare Part D between the state, Social Security and CMS. And if we add in addition to all the other entities that exist, if we add another layer of whatever you might want to call it, complexity to the enrollment process, there will be more possibilities for data errors and enrollments to be lost and enrollments to be delayed.

Thank you.

Anthony Culotta: Thanks, Trish. I just wanted to - just to allay your fears on the first point. I mean, I think the announcements specifically mentioned that with the coverage options that will be under review include original Medicare, Medicare Advantage, Part D, Medigap and employer coverage. So we'd expect that, you know, everything will be on the table.

On the second point, I mean, I understand what you're saying. I think any demonstration would definitely evaluate the enrollment complaint rate under the current system where obviously there are some versus under, you know, any given state with this kind of a contractor. Thanks.

Operator: Your next question comes from the line Norma Almanza from Texas. Your line is open.

Norma Almanza: I think my comments have already been reiterated. Thank you.

Anthony Culotta: Okay, thank you. Operator, we're going to go ahead and move on to the second - to the next topic and Kevin's going to start talking.

Kevin Simpson: The next one is on the plan marketing activities in the demonstration site. Let me - before we open this one to comment, clarify something that I've seen in some of the written comments that apparently we confused some folks, the way we wrote them.

We were not proposing in any way that the demonstration project would be a conduit to plan marketing information. The question that we are actually trying to post here is whether we should implement further restrictions on plan marketing in the demonstration side to go above and beyond the restrictions that exist in the rest of the country, up to - including completely prohibiting any kind of planned market.

So that - then we raised something - a question has been raised here. When we looked at similar functions that are done by the states through Medicaid enrollment brokers, some of the states have pretty restrictive limits on plan marketing. And so the question here is not should we have a contractor as a conduit for plan marketing, the answer to that is no, period.

The question is, should we restrict plan marketing in the area where we conduct the demonstration. So with that, Sarah, we'd ask you to open it up for questions.

Operator: Again, if you would like to ask a question, please press star then the number 1 on your telephone keypad.

Your first question comes from the line Joseph Dupele from Virginia. Your line is open.

David Richardson: Thank you. Actually, this is David Richardson at Maximus, but Joe is here as well. We are a Medicaid enrollment broker and a SHIP enrollment broker. I have a lot of experience and the first one I would like to thank Tony but also say that most of what we heard previously we agree with. I think this is a really tricky question and one where we're not so much going to make a recommendation as raise some consideration.

In the Medicaid world typically plans are highly restricted. In fact, in all but one area we're familiar with, plans are not only restricted in marketing but they are not permitted to enroll the beneficiaries directly. That function can only be performed by the enrollment broker. There's one state in which there is something called plan-facilitated enrollment; meaning that the plan can in effect take an application which is then passed back through the enrollment broker.

So enrollment is - and roles and responsibility of enrollment is probably more important and drives the decisions about marketing and marketing restrictions. So in a pure model plans would not be able to enroll and the enrollment broker working with SHIPs and other organizations would in effect accomplish that.

Having said that that's the pure model, the Medicare program has a long history of plans that have a lot invested in their business model and that may or may not be feasible. So another model might be that this is more common to what exists today is that plans would be able to enroll but beneficiaries

would know that they could go to an independent entity if they chose to do that.

I think the decisions about marketing follow from that decision. And I think the best way to think about that is it's 175 pages of the Medicare Marketing Guidelines, and you would almost have to march through that document based on your demonstration design and determine what the changes and, in some cases, the tweaks would be, so.

Anthony Culotta: Thanks, David. We appreciate the thoughtful comprehensive comments that you've submitted.

Any other comment?

David Richardson: No. That's good, thanks.

Kevin Simpson: Okay.

Operator: Your next question comes from the line of Paul Precht from the District of Columbia. Your line is open.

Paul Precht: Yeah. I just wanted to emphasize two points for consideration here. One is - and I think this was raised before. There is now the prohibition on unsolicited contact, and a lot of folks have put the message out there if somebody's going door-to-door or somebody's calling you unsolicited they're already breaking the rules.

So I think in an environment where you want direct outreach from the Enrollment Assistance Program, you really want to make sure that the plans are not sort of taking advantage of that, you know, the rules are different in this area. Or you may receive a call-type message and having their agents or

enrollment folks calling people and sort of getting around that restriction, you know, would still exist.

And then I think - and so I think that argues for more rather than, you know, tighter restrictions on what plans could do where the enrollment is, in particular in regard to agents.

And the other point I'd make - and this is in our - just briefly mentioned in our comments. To the extent we're testing out a different way for folks to get the information and - that they need to enroll, we, you know, could in fact be testing, "Well, okay, if we do this system rather than the current commissions-driven system, do people get better information and make better choices?"

And then when you look at expansion, you might be talking about a system that sort of supplants the current system. And that has benefits, I think, that could be more systemic in that, you know, where we would no longer have plans paying out of their Medicare subsidies, you know, 400 bucks or more, I guess, over the succeeding years for enrollment, and that means more money for benefits.

Anthony Culotta: A very interesting point, Paul. Getting back to the first point that you made, and also again I think it ties back to the points that I think came from Elaine Evert - if I got her name right; Eakin from California Health Advocates, that, you know, one model we're definitely looking at is this something where, you know, the outreach may consist of the original - the initial enrollment packets that people got when they first become eligible for Medicare. And sort of in a given state, you know, you might get something that says, this is available to you, and we just promote it that way as sort of something about outbound calls saying - which might, you know, get around some of the liability issues that were raised.

Kevin?

Kevin Simpson: Thanks, Paul.

I think we have one more question on this topic and then we're going to - or one more comment on this topic and then we'll go to the next one, so.

Anthony Culotta: And I'd also be interested in hearing something from a plan perspective...

Kevin Simpson: Yeah, yeah.

Anthony Culotta: ...as we go - as we move along.

Operator: Your next question comes from the line of Mary Sullivan from Massachusetts. Your line is open.

Mary Sullivan: Thank you. It's just a comment.

From my grassroots perspective, we see, you know, we deal mostly with our emphasis being on the beneficiary and their concerns. But we also recognize that we need the comprehensive information from the plan. We need to be able to get that information about the formulary. So if there were some structured way for that marketing to occur whether it be one educational format so that we can get that comprehensive information.

But, you know, to have it in an open format where they could be marketing to a site, we would find it - especially what - with our situation now, we would find it intrusive to our day-to-day operations of trying to help the beneficiary who is our primary focus.

So what we would like is to see the marketing occur but at a very structured, very, you know, maybe in an event or something where there's this specific guideline that we could have that comparison of plan to plan and be able to share that with the beneficiary.

Anthony Culotta: Yeah, I think that makes a lot of sense. I mean, I don't want to give - leave anybody with the impression that we - by saying that they wouldn't be a conduit for marketing would mean that they wouldn't have materials, you know, from the plans that people could use in making a choice, you know? But there will have to be, as you said, some well thought out guidelines about what kind of materials would be appropriate.

Mary Sullivan: Right, right. Thank you.

Kevin Simpson: Thank you.

Go on, operator.

Anthony Culotta: Yeah, you're back up, Kevin.

Kevin Simpson: All right, number 3, the demonstration site selection strategy. A couple of key areas that we want to focus in on here was we do - how we roll this out. We really thought that - from a feasibility perspective that there may be some value to us focusing on some targeted beneficiary populations. I know in looking at some of the written comments that have been submitted so far some folks have some ideas about that, and they'd like to share that with us today.

Should we start with a small group and expand over time or should they focus on a group? And then looking at, you know, how long should we take - you know, how long should we expect this thing to get rolling given all the coordination that we - that was talked about?

And I think another area we see here is the - how we should interface with SHIPs, AAAs and other community-based partners? I know we touched on that as well as folks with other thoughts. We'd certainly welcome them as part of this discussion as well.

So Sarah, if you could open up for questions or for comments here. Thanks.

Operator: Again, if you'd like to ask a question or if you have a comment, please press star then the number 1 on your telephone keypad.

Your first question comes from the line of Joseph Dupele from Virginia. Your line is open.

David Richardson: This is David Richardson again. Sorry to get back on so quickly, but this is an area where we actually have pretty strong recommendations.

We understand why CMS seems to be inclined to want to target because of scope and feasibility issues. But we would recommend a different approach where in effect you pick an area that's representative of the country in some more general way and expose the broader population. Because even though we do a lot of this work the reason that I think we're doing a demonstration is we're not exactly sure until we do this what's going to work for what population.

So, for instance, there's a lot to suggest that it would be most beneficial for low-income or non-English-speaking, but we could actually find that the population that benefits the most from this is the higher-income, higher-educated population. So I think in that regard we recommend that if CMS wants to limit the demonstration, they do it, I guess, by virtue of the size

of the territory but collect data so it can determine - the agency can determine which populations benefit the most.

On the issue of SHIPs and others, we recommend a recognition that a lot of entities, not just SHIPs and this contractor which may or may not be a SHIP and 1-800, a lot of people are involved. There needs to be true integration of business processes. And therefore, if the entity is not a SHIP, I think very definitely some extensive subcontracting to take advantage of their community presence and the presence of other organizations is highly desirable.

Anthony Culotta: Okay. Thank you, Dave.

And I just want to say to everyone that, you know, please don't hesitate for a second to get back on because, I mean, I consider this - this is basically a public meeting; they're all on the phone. So, you know, for those of you, I know, I've never heard you - limit yourself to making one remark in the past, so don't feel like you're limited here. Okay.

Operator: Again, if you would like to ask a question, please press star then the number 1 on your telephone keypad.

And your next question comes from the line of Elaine Eakin from California.

Your line is open.

Elaine Eakin: Thank you again. I'm with California Health Advocates.

The two groups that we identified that would need most assistance and - whether it's with this demonstration or another one or just in general are

people with disabilities and people with limited English proficiency. And I think somebody or a couple of people mentioned that early in the call.

People with disabilities, we found that many of them do come to SHIPs after their Medicare has become effective. They didn't know they ran into some coverage problems, and they find out later that they have Medicare. So I think that that's the group that really needs more information and outreach to them.

And then also people with limited English proficiency, it takes a lot more resources to reach them; working with ethnic organizations definitely help, but in California especially there are so many of them. So help is definitely appreciated here. Thank you.

Anthony Culotta: And we appreciate that.

Kevin Simpson: Elaine, this is Kevin. I have a quick question for you on that because I know you've talked about making sure that this project doesn't usurp what a SHIP is doing. Or - in identifying those two groups, are those two groups where you think that there's a - the best opportunity to supplement what the SHIPs are currently doing in those areas?

Elaine Eakin: Yes.

Kevin Simpson: Very good, thank you.

Operator: Your next question comes from the line of Ginger Zielinzie from Pennsylvania. Your line is open.

Ginger Zielinzie: Hi there. Thanks again. Thanks for saying that we could speak twice.

I just wanted to touch briefly on the targeting aspect. We have a lot of experience with targeting, and we have found when you're conducting direct mail that whether it be - for example, what they call or previously just mentioned about, a group of people that may have disabilities. If you want to focus on that population, there are ways using data to target specific populations to glean specific information. And I think a demonstration project could also say they're interested in three different populations, we're going to target those different populations and really compare the results.

And secondly, I think it's important to note that there are call center functionalities that can certainly serve people with limited English capabilities. We use a language line here so we can help an individual in 70 different languages, and I think that that's an important point as well.

And then, finally, our work in Philadelphia, we've been able to work closely with - we are not-for-profit, but then other community-based organizations and - work with the SHIP organization to really create a more 360 degrees. So, if an individual needs help from an individual in the community and we're on the telephone, we can refer and vice versa. So there are, I think, creative solutions on the community level to use what technology may also be able to supplement in terms of helping individuals most accurately gain access to that complex information.

Anthony Culotta: Thank you. I know that, you know, dealing with the limited English populations is a big part of some of the Medicaid projects. Of course, it's also an extensive part of it then. Thanks.

Kevin Simpson: All right. I think we're - I don't think anyone else has any view on that particular topic, so we'll move on to the next one which is demonstration site selection. And it's just a big part for us. Where would we do this? And we've laid out a couple of thoughts that we've had in terms of looking at areas where

there's really significant penetration of MA plans currently. Also looking at areas where we've had higher rates of complaints involving plan marketing and that sort of thing.

But, you know, we're open to ideas here. You know, we've heard some suggestions about particular populations that maybe more in need. So, we'd just like to hear from you in terms of what your thoughts and ideas may be about criteria we should look at when we look at where we should place this particular project.

So, Sarah, if you could just queue people for that, we'd appreciate it.

Operator: Again, if you would like to ask a question or if you have a comment, please press star then the number 1 on your telephone keypad.

Your first question comes from the line of Norma Almanza from Texas. Your line is open.

Norma Almanza: I guess my comment on that is the way you've talked about it is I thought we've already expressed the concern that this project should not focus on enrolling more people into private sector Medicare; rather, it should be on enrolling people - helping people enroll into plans that work for them whether that be original Medicare or whether it be a standalone drug plan or a Medicare Advantage plan. So I'm concerned to hear that focus again on Medicare Advantage penetration.

This is one place where I do think we need to see where there are problems, where we see that there are even potentially eligible clients who are low income and not getting into the assistance. And every year, we try to do outreach. But I guess my main concern would be that it not be focused at

trying to either further promote private sector or to base it on let's-do-it-that-way.

Anthony Culotta: I appreciate your concern there, and I can assure you this is not aimed at promoting Medicare Advantage program. But I think, you know, this is why we're asking whether or not actually that should be a consideration in terms of where we will put this. Because if you look back - if you think back at some of the reasons behind this, you know, one of them is that there are, you know, allegations and there are - there's definite marketing abuse in some places.

And so, if you put it in a place where there's a lot of marketing complaints, I think by definition that will be a place where there's a lot of Medicare Advantage penetration. Not that, you know, I'm not trying to say anything negative about Medicare Advantage there.

I'm just saying that absent the Medicare Advantage and Part D there is no marketing. So, you know, it's not like we're marketing the Medicare program. We're getting complaints about our - you know, about sending out Medicare a new handbook. So that's kind of, you know, why we raised that as a possibility. Okay.

Norma Almanza: With all of that being said - I'm not speaking for anyone rather than myself, but I'd like to suggest Texas. We have rural, we have urban, we have different language challenges, and we've got a SHIP that happens to also be the AAAs and other organizations such as the Department of Insurance.

Kevin Simpson: And yes, great food music, too. So that's another attractive option.

Anthony Culotta: But I would say that - I think at one point we had looked at what states might fall under what criteria, and we've cited perhaps that wasn't the best thing to,

you know, to make public. You know, just - but I know that Texas fits the criteria just for your information.

ORDI is cringing at that remark so just put it out there.

Operator: Your next question comes from the line of Georgia Burke from California. Your line is open.

Georgia Burke: Yes. First of all, California has great food, too and lots of limited English-proficient folks.

I just wanted to just add one more element in terms of kind of looking at areas, which is that there's more than 2 million, as we understand it, limited English - low income subsidy individuals who are in plans where they are paying a premium. And probably many of them would not need to be paying a premium if they made better choices or looked carefully at other plans that might meet their needs. So if you look at the demographics of where those 2 million folks are, that might be another element to put into the mix.

Anthony Culotta: We appreciate that. Thank you. Just for your information, I was referring to our office of demonstration when I was saying who was cringing.

Kevin Simpson: And with that, I think that's all in queue and thank you for that particular one.

Let's move on to the last one and then we'll certainly open it up for any general comments folks have at the end if they have any comments have left.

Kevin Simpson: The last one is one enrollment assistance contractors. And I know that, you know, there - in the contracting, an element of this is down the road of it and the details of it are for another day and time. But the enabling legislation around this demonstration specifically says that we need to get public input,

and we thought this would be a good opportunity to do that, about the selection criteria that we would use as part of our acquisition strategy and, well, performance measures or performance standards we might use to engage the work of the contractors.

So, to fill that mandate and to get your good ideas, we wanted to add that in here and ask for your comments on that at this point.

So Sarah, if you'd ask folks to queue up, we'd appreciate it.

Operator: Again, if you would like to ask a question, please press star then the number 1 on your telephone keypad.

And your next question comes from the line Elaine Eakin from California. Your line is open.

Elaine Eakin: Hi. I actually pushed star-1 before we moved on to the - to this current section. My comment was about the previous one.

And I don't know if there's a way to find out how many or which state has the most disenrollments due to misleading marketing, if there's a way of finding that out. And that might be a site for the demonstration and that's all that related to the previous section. Thank you.

Anthony Culotta: Thanks. I don't think we've actually thought about that one. Thank you very much.

Operator: Your next question comes from the line Joseph Dupele from Virginia.

Your line is open.

David Richardson: David Richardson again. Tony, you made a mistake in suggesting I could ask as many questions as I have. So I'm back.

I did have a question on the demonstration place selection. And I wonder if Tony or Kevin could comment on how they see research design and evaluation fitting into this activity. Is this a demonstration that would have a very formal design, who's going to do that. Can you comment on that at all?

Kevin Simpson: I think what were - I think at this point, we look for suggestions from the folks who - you and other folks on the line. I think, you know, and obviously something you want to follow up with. I do have something we are looking at right now. I don't think we're prepared to lay that out at this point. So to the extent that folks on the call today, others have suggestions or ideas about how you think we're going to proceed with that. Just like every other design element to this, we are seeking comments and ideas.

Anthony Culotta: I think it's safe to say that we'd anticipate a formal demonstration and evaluation, right?

Woman: Indeed.

Kevin Simpson: Normal procedures.

Anthony J. Culotta: Yeah.

Woman: Yeah, just the contractor.

Anthony Culotta: Okay. So I gather that we don't have any more comments in this particular item. I know that we've gotten a lot of comments, for example, on the demonstration site selections, you know, through our email box, and that will continue to remain open.

So I just want to offer people that opportunity of, you know, if they have any general remarks at this point, feel free. I'll give a minute for that and then we'll resume.

Anthony J. Culotta: All right. So do we have anybody queued up to add any additional comment?

Operator: Your first comment comes from the line of Randall Downey from Nevada. Your line is open.

Randall Downey: All right. Thank you. Thank you for the opportunity. I guess it's your afternoon.

I'm just concerned on the final - the enrollment assistance contractors. The way you have it worded in the announcement really sets up a way of operating the system that kind of predefines what kind of contractor you're going to be looking for. And I'd be concerned that it limits to a call center run by professionals.

I'm with Nevada SHIP. We're a volunteer organization. I think we do a bang up job of reaching out to our disabled and Medicare eligible community. And I'm just concerned that you've limited by your language here the type of contractors you're actually be looking for.

Kevin Simpson: Thanks. I think, you know, what we thought of a way we worded that -- and I appreciate your perspective on it -- was to really take the potential functions that we had identified and then carry them over here.

I think as Tony mentioned earlier, when we ultimately get to the point of first having defined what the particular functions are going to be as part of the

demonstration project, the location and the size of the beneficiary population that we're targeting either - whether it's a specific deal targeted or within the geographic area to be targeted. At that point, obviously we have to write out an (RFP) that might identify the specific capability that a contractor would have.

And so, you know, I think here, we're just trying to get some basic feedback. Perhaps, it was too specific given the way we outlined the original function. But when that time comes, actually the contract and its requirements will have to reflect the function for the project.

And I think you'll be seeing in the past too or times when, you know, contractor - I think it was mentioned earlier by a comment that perhaps, you know, a lead contractor might be able to fulfill one or more of these functions would come in, subcontracts with other organizations to fill others.

So they are a variety of ways for potential contracts could be structured as people put this together, and I would expect we'll see several of them when that time comes.

Operator: Your next question comes from the line of Paul Precht from the District of Columbia. Your line is open.

Paul Precht: Hi and sorry if I'm going over my quota. But I did have three remarks on the three different areas that I thought worth bringing up.

One is, you know, when you are talking about either looking at a site or location or state for the scope of the demonstration versus the targeted population. I think there's some room for flexibility there, both you could do, you know, a mix obviously, or you could have a collective site and also include specifications for target populations and - that you would want to - the

contractor to address in any particular site. Because I think there are definitely folks who need this type of assistance more than others. And even if the overall scope is broad, I think it would be useful to have some criteria for making sure that those populations are targeted.

And then there's been a lot of concern raised about whether, you know, this does not be sort of another conduit into Medicare advantage and that the full range of options including Medigap supplemental coverage be part of the function. And I think, you know, you all have spoken to that very clearly.

As you look at site selection, I think one of the factors in there will be which states provide the kind of access for Medigap supplemental plans that is broad enough to encompass the folks that are going to be reached by this demo. So people with disabilities some states allow, provides guaranteed issue rights and others don't.

Some folks have guaranteed issue rights at different times of the year or continuously. So I think that that's another factor to weigh in as you're looking at site selection for determining where an enrollment contractor could best provide the full range of options if there - because obviously I wouldn't think that they would be doing any medical underwriting.

And then finally on the performance criteria, I think Bill Vaughn, you know, mentioned the ability for folks to save money when their drug regimens are matched up against plan through the plan finder. I think that that would - is one area where you could measure how well an enrollment contractor does.

I think the degree to which you - to which people are - to the extent they go into Medicare Advantage, go into plans that rate higher on quality ranking. I think that that would be an important criteria. I don't know if there's any evidence that those will factor much into consumer consideration now, but

they simply affect the care people get, as well as other benefit criteria that might apply toward to your plan selection on the Medicare advantage side regarding your, you know, out-of-pocket caps and things of that nature.

So I'll just leave it there and, you know, thanks for this opportunity.

Anthony Culotta: I appreciate that, Paul.

I think you're right to the point about Medigap. Looking at different states of Medigap programs, I think it's something everyone was nodding their heads, too, around here.

And also, I just want to make one thing clear that, you know, in terms of the site selection, I think - I mean not that this is the kind of parameter of this. But I think it's safe to say that we always intend that there would be a limited site, nothing like national in scope but more like one or two states.

And then within those states whether or not we should have - the question would be whether or not we will have a limited population or try to address, you know, the entire Medicare population or the incoming population, the (LIS) population, et cetera. So there's every thought to begin with, you know, try to address the national population.

Okay. Next person, operator.

Operator: Your next question comes from the line of Ben Smith from the District of Columbia. Your line is open.

Ben Smith: Hi. Thanks for taking my call.

One of the things that I would recommend that once you go to the site selection process is in the development of the RFPs for the contractors is really consider what the - an adequate startup of time is for bringing those folks on board. And then consideration of the startup time, think about what you anticipate the IT requirements are going to be and data collection, usability of systems and things like that.

If you're expecting a quick startup then those were probably - this requirement will need to be limited. Also, you might considering depending on the resources you have available of using separate contractors for the delivery of the service to the beneficiaries and those that are actually delivering the performance of that, the evaluation piece. So you might consider those as being actually separate contractors.

And just kind of one more comment and the selection of a contractor thinking about how you're going to measure the strength of the local partnerships which are going to be absolutely essential for the contractor - the enrollment assistance contractors. They're going to have to have good local connections there, either with SHIP or other community-based organizations that are delivering services there.

What type of criteria are you going to use in the (RFP) to make a determination. There's solid partnership because those are certainly things that can disrupt the whole demonstration project.

Thanks.

Anthony Culotta: Thank you. There're definitely some things we're thinking about here. And with respect of the first point, you know, I think that's exactly why we want to sort of get your comments on a timely basis if anybody has anything beyond us so that we can - you know, we understand it can take a while to get this set

up. So we need this in some kind of a reasonable timeframe, you know, next year to 18 months then we need to start moving on the contracting side.

Kevin Simpson: I think we have two more comments in the queue. That should probably take us right up both at the end of the call.

So, Sarah, why don't you go ahead?

Operator: Your next question comes from the line of Norma Almanza from Texas. Your line is open.

Norma Almanza: On that Number 5 especially the ending sentence, there were - CMS is looking at the strategies that states have used in their acquisition of Medicaid enrollment brokers which we've heard about already. I think that somewhere within the design of this demonstration needs to be even within it an independent monitoring.

For example, when we first in Texas went with a Medicaid broker, consumers union and other organization created and were able to get funding for an independent non-profit that was the complaint source for the Medicaid folks enrolled into Medicare Advantage. And I think that would almost be a self-evaluation of, you know, what you did. Did it really work?

So I'm looking for that kind of local. How do we know besides the fact if the focus is going to be did they get enrolled in the plan that works for them, but they're still having problems, and what are the levels of problem.

Kevin Simpson: Thanks, Norma.

It's a good point, and I know that it's looking at - I guess it's more than 29 states now that have on the Medicaid side engaged with enrollment brokers.

There's a lot to learn really good experiences and some that got off from a rocky start.

I think you raised a good point of really making sure that we got our homework which we are doing to make sure we avoid those rocky starts that folks have experienced with similar contractor, certainly different in any way but similar. It's a good point, (Norma). Thank you.

Operator: Your next question comes from the line of Patricia Nemore from the District of Columbia. Your line is open.

Patricia Nemore: Thank you.

Hi. This is Trish Nemore again from the Center for Medicare Advocacy. I'm thinking that since this originated in the BBA that probably the original idea was we're heading into new territory with these private plans, and the states have had some experience with enrollment brokers and maybe we should be looking at that too.

But we're now 12 years out from the BBA, and we have all the wealth of experience that people have spoken to on this call including mostly the SHIPs but other community-based organizations and other trusted entities that are helpful for helping people make these enrollment decisions.

And I guess I was just realizing that in the course of an hour and a half, very little time has been devoted to whether this should go forward at all.

Although, I believe Tony said at the beginning, it's not set in stone to go forward. But it increasingly focused on specifics of the site selection. What could be the criteria? What should be the standards for a contractor which moves in a very short time from - here's an idea, is it a good one to how we're going to implement this idea.

So I just want to hold up a contrary position that I think we have heard reiterated in different ways from different people on the call that there are very good resources on the ground operating now, and they've all been underfunded always. This is a massive job. It's very complicated. And it may be that adding another layer of confusion and which door do you go into and so on is really not the right way to proceed.

So I hope you would hold that view fairly brightly as you consider the comments made today.

Anthony Culotta: Trish, I think you really hit a lot of good points to wrap things up because I mean, you know, and I welcome comments on whether or not this is a good idea to proceed with at all and, you know, I like to see those. You could do it in the next 10 days, so it'd be quite helpful.

You know, you brought up some several issues about this is part of the BBA and things have changed a lot since then, and we understand. I think a question might be asked is why this hasn't happened since this was actually in the BBA up until now.

I think we do take the statute - provides the authority, but that doesn't mean we need to move forward with it. And the goal is certainly a little bit different than it was set up, you know, 10 years ago and a lot has happened since then. I don't think we actually need, you know, specific statutory authority to do a demo but it does help. So again, you know, I want to hear people's ideas on that.

With respect to what exists now, I think that you also have to remember that - let's say we're here to do a demo in a state, and we found out that certain things are extremely effective. That's not to say that we then have some

contractor working the whole country. It could well be that things that we learned through the demo are then implemented through existing, you know, entities like SHIPs or 1800.

So I think it could be sort of a win-win situation where we learn something in the small, you know, small context and we expand it to existing partners. So I'm just saying, you know, there's a lot of ways of looking at this.

So I think that's pretty much - I guess the last thing I wanted to add in terms of a couple of logistics are basically we heard a lot of things. I won't promise some kind of panacea because obviously, you know, the more personalized this gets, the more languages that are involved, the broader it is. And to some extent the better, but to another extent, you know, the more it's going to cost. And so, we live in a world of constrained resources and conflicting interest, you know, both from the federal perspective and from the partners' perspective.

So believe me, we're taking all that into account, and we've been trying to make the best recommendation possible with your help.

So in the next few weeks, our project team will be looking at your input. We're going to combine your input with our ideas and make recommendations on leadership about whether to proceed, and if we do proceed, you know, under what it would look like.

So we would like you to continue to submit your thoughts and comments to our project email box which is medicareenrollmentdemo@cms.hhs.gov. And if you're on the call, you probably already have that information.

We have a website, and we will continue to provide project updates on the Web site. And basically, that's about all I have to say. Kevin, anything you want to add?

Kevin Simpson: I just want to thank everybody. I think some great points have been raised so things for us to think about as we go forward. I appreciate everyone's time and thoughts and input on this project.

Anthony Culotta: All right. Thanks everybody that are on the table for all the work that you did. Talk to you all soon.

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

END