

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**Moderator: Donna Cupina**  
**February 5, 2013**  
**2:30 p.m. ET**

Operator: Good afternoon. My name is (Beth) and I will be your conference operator. At this time, I would like to welcome everyone to CMS Stakeholder and Partner Education Series Webinar.

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 one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Donna Cupina, you may begin your conference.

Donna Cupina: Hello, everyone. This is Donna Cupina from the Division of SHIP Relations, and thank you for joining us today. This is our second combined SHIP Forum and National Training Program audio webinar, which is now called the CMS Stakeholder and Partner Education Series.

We've combined the calls into a single webinar as part of our ongoing efforts towards efficiency and consistency. We have two presentations for you today, first you'll hear from Heidi Edmunds on the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program, and then we will have an overview of Indian Healthcare from Jim Lyon.

The call will be muted while the speakers are presenting. After each speaker, you will have an opportunity for questions and answers, and (Beth), who is our moderator today, will give you instructions on how you can ask your

questions. If you have questions during the presentation, you can feel free to submit the question via the chat Q&A box that you should see on the left-hand side of the screen. Simply type your question into the box and click on the arrow button to send it to us.

The materials for today's call are also available on the left hand side of your screen, in the file share box. To download us a file, click on the name of the file and then click Save to My Computer. A new window may open with a link that says Click To Download. If that happens, just click and select either Save or Open to access the materials.

And with that, I'll turn the call over to Heidi.

Heidi Edmunds: Thank you, again, and good afternoon – and is it still good morning, or good late morning to those on the west coast. My name is Heidi Edmunds and I'm with the Division of DMEPOS Competitive Bidding. I'll be going over some slides briefly to explain the upcoming competitive bidding program that's getting ready to expand to 91 areas in July. There will also be a time for questions following my presentation.

Except for the nine areas where competitive bidding program is currently in effect, Medicare pays for most DMEPOS items using the fee schedule.

For most of the items, the fee schedule payments are based on historical charges, adjusted for inflation at times, and not on current market prices. Numerous studies by the Office of the Inspector General and the Government Accountability Office have found that the prices paid by Medicare for a certain DMEPOS items are excessive; sometimes three or four times retail prices and the amounts paid by commercial insurers.

Clearly Medicare needs a better way to pay for DMEPOS items. Medicare's competitive bidding program for DMEPOS is an important step towards paying appropriately for medical equipment and services. The program reduces out of pocket expenses for Medicare beneficiaries and saves the Medicare program money, while ensuring that beneficiaries continue to receive quality products from accredited suppliers.

The competitive bidding program strengthens protections against Medicare fraud. Under Medicare Competitive Bidding, DMEPOS suppliers have to meet certain financial and quality standards that make it harder for fraudulent suppliers to enter the Medicare program. Also, reducing excessive payment amounts makes the competitive bid items less attractive targets for fraud and abuse.

Who will be affected? The Medicare competitive bidding program applies to beneficiaries who have original Medicare and whose permanent residence is in a zip code that is part of the competitive bidding area, or CBA, or if they get certain items while visiting a competitive bidding area.

A beneficiary's permanent residence is the address where Social Security mails his or her benefits check. The round one competitive bidding areas are in metropolitan statistical areas, or MSAs. The national mail order program CBA includes zip codes in all parts of the United States. Beneficiaries can find out if a zip code is in a CBA by calling 1-800-Medicare or TTY users can call 1-877-486-2048. Beneficiaries who live in a round one competitive bidding area can find this information on [medicare.gov](http://medicare.gov).

The round two zip codes will be added to [medicare.gov](http://medicare.gov) in the future. Beneficiaries can find the round two zip codes on the Competitive Bidding Implementation contractor's Web site at [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com). Medicare Advantage enrollees can use any suppliers designated by their plan. Their plan will notify them if their supplier is changing. If beneficiaries aren't sure if they need to change, they should contact their plan directly.

The products that are included in the round two – these are the competitive bidding products that are included in round two. Most of the products included in round one are also included in round two. Medicare is also adding some additional items. These different items are indicated on your PowerPoint presentation in bold italics.

As I mentioned earlier, Medicare will be starting a national mail order program for diabetic testing supplies at the same time as round two. The national mail order program will include all parts of the United States,

including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

This program is designed to ensure that beneficiaries continue to get quality supplies while they save money. The term mail order includes all home deliveries. When it starts, beneficiaries will need to use Medicare national mail order contract suppliers for Medicare to pay for their diabetic testing supplies that are delivered to their home. If they don't want their diabetic testing supplies delivered to their home, they can go to any local store that is enrolled with Medicare to buy them there.

Due to the new requirements in the Medicare law, Medicare will pay the same amount for mail order and non-mail order diabetic testing supplies when the program starts. National mail order contract suppliers cannot charge more than the deductible and 20 percent coinsurance. But local stores may charge more. Beneficiaries who use a local store can check with the store to find out what their co-payments will be.

Using Contract Suppliers. If the equipment or supplies ordered by a beneficiary's physician or treating practitioner are included in the competitive bidding program, where the beneficiary lives or visits, the beneficiary most almost always gets his or her equipment supplies from a contract supplier from Medicare to help pay. Treating practitioners would include a physician assistant, a clinical nurse specialist, or a nurse practitioner. However, the beneficiaries' doctor or treating practitioner can sometimes supply a walker or a folding manual wheelchair to the beneficiary when he or she is getting other medical care, even if the doctor or practitioner isn't a contract supplier.

Similarly, if a beneficiary is hospitalized and needs a walker or folding wheelchair, the hospital can supply these items while the beneficiary is admitted or on the day of the beneficiary's discharge from the hospital. The Medicare payment amount will be the new lower competitive bidding payment amount.

If the beneficiary lives in a skilled nursing facility or a nursing facility, the facility may be able to supply the equipment or supplies directly if it becomes

a contract supplier. If the facility does not become a contract supplier, it must use a contract supplier from the CBA.

Beneficiaries in round two, who are renting certain medical equipment or oxygen when the program starts, may have the choice to stay with their current suppliers. Non-contract suppliers can become grandfathered suppliers and continue to rent items to people with Medicare who permanently live in a CBA if they are renting the item or items to the person when the competitive bidding program starts in the CBA.

When beneficiaries use grandfathered suppliers, they are still responsible for their 20 percent coinsurance and any unmet Part B deductible. If a beneficiary's current supplier of rented equipment decides not to become a contract supplier, the beneficiary must almost always switch their contract supplier for Medicare to help pay.

The competitive bidding program has special protections to make sure beneficiaries get the specific types of medical equipment they need to protect their health. If a beneficiary needs a specific brand of equipment or supplies or needs an item in a specific form, the doctor must prescribe the specific brand or form in writing.

The doctor must also document in the medical records that the beneficiary needs this specific item or supply for medical reasons. In these situations, a Medicare contract supplier is required to furnish the exact brand or form of the doctor prescribed or work with the doctor to find an alternate brand or form that is safe and effective for the beneficiary or help the beneficiary find another contract supplier that offers the brand or form prescribed.

If a beneficiary travels to or visits an area where the competitive bidding program has started and needs to get equipment or supplies that are part of the competitive bidding program for that area, they must almost always get those supplies from a contract supplier for that area. If a beneficiary uses a non-contract supplier, the supplier is required to give the beneficiary an advance beneficiary notice, or ABN, stating that Medicare will not pay for an item or service. If a beneficiary doesn't sign an ABN, he or she is not responsible for

payment for the item or service. Beneficiaries who travel to a non-CBA will be able to use any Medicare enrolled supplier.

That concludes my presentation. I've also included at the end of the presentation, an appendix listing out the round two metropolitan statistical Areas in your program for your convenience to look over to see if that area is included in the program. At that time, this concludes my presentation. Thank you.

Debbie Higgins Before we go to question-and-answers, Walt Gutowski is going to tell everybody where resources are available for the DMEPOS.

Walter Gutowski: Thank you, (Debbie). This is Walt Gutowski in the CMS Office of Communications. I just wanted to remind everybody that we do have some information resources available for your reference to supplement what you heard today from Heidi regarding the round two of the competitive bidding program and the national mail order Program, and they can be found on cms.gov. You go to the Partner section and then you click on Education and Outreach, actually it says Outreach and Education, then Partner with CMS, and then there's a DMEPOS tool kit.

The actual link is

[www.cms.gov/outreacheducation/outreach/partnerships/DMEPOS\\_Toolkit](http://www.cms.gov/outreacheducation/outreach/partnerships/DMEPOS_Toolkit). But the easiest thing to do is just go to cms.gov and look for the Outreach and Education section and then Partner with CMS. You'll see there's a lot of information in there from round one which we implemented a couple of years ago. But also there's some in round two; under Downloads, you'll see a Partner FAQ dated July 2012, also a partner program preview from May of 2012. And those pieces will give you some contacts and background on the purpose of the program, a little bit about the history, the success we've had so far in round one and the value and benefits of the program for beneficiaries.

In addition, we've been conducting a series of educational programs for partners and referral agents in the form of webinars; our regional offices have been doing those over the past week or so. In fact, the first series of five concluded today, some of you might be aware of them already.

We've also been developing a drop-in article that you'll hopefully be seeing placed in your local media to help begin to educate beneficiaries about this. The education plan we have right now is really – seriously (inaudible) to round one where about six months before the program began, we wanted to really begin to reach out aggressively to referral agents and partners such as yourselves to educate you about the program so that you could help us educate beneficiaries when the time comes.

And about three months before the program begins, once we announce the contract suppliers, we'll do some very proactive outreach to beneficiaries in the form of mailings to give them information about the program and local outreach presentations to our regional offices in all the areas of the program, and we'll be looking for you all obviously to be a key part of that to help us make sure that beneficiaries understand this.

The biggest resource to remember down the line is 1-800-Medicare, as always, which is the – the CSRs there will be trained thoroughly in being able to help people find contract suppliers. And of course, there's a supplier directory on [medicare.gov](http://medicare.gov) which has actually been revamped and made much more user-friendly for folks who want to go on there themselves or for referral agents who help beneficiaries obtain these items to help them navigate through it more easily and find contract suppliers that are appropriate for their needs.

So that's a quick nutshell in terms of our plans for right now in terms of education and outreach, and I'll just open it up to general questions, I guess, for Heidi or myself.

Operator: At this time, I would like to remind everyone, in order to ask a question, star one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Susan OK, while Beth is getting the calls, I had a couple of questions that came in via chat for Heidi. So, Heidi, can you talk about what are the requirements for hospitals if they recommend wheelchairs or crutches or something? Do they need to be certified CMA suppliers?

Heidi Edmunds: The requirement for hospitals is hospitals are allowed to issue a walker, a folding wheelchair, during the admission or on the date of discharge.

Sue: OK. And what about – we have a person with Medicare who lives in one state but their payee who takes care of their affairs is in a different state? Which state rules apply?

Heidi Edmunds: OK. So, it's the address of where the social security check is mailed to the beneficiary, but that area falls outside of a competitive bidding area?

Sue: Yes, so if the check is mailed – well, maybe get her to come on and give us some more details. She told me that her client lives in Oregon but the payee is in Santa Barbara. So, I'm not sure where the check actually goes. We'll have to get more details for you.

And one more, people are a little bit confused about getting diabetic supplies because they're used to walking into the store. Can you address how people can continue to get their diabetes supplies?

Heidi Edmunds: Yes, if you prefer to receive your diabetic testing supplies in a local store front, you can continue to do that. And with the new law that was just passed, the price will be the same as the competitive bidding rate. However, it could be different, so we just want to caution people to make sure to check the price with the store prior to payment.

Donna Cupina: (Beth), are there any questions in the queue?

Operator: Yes. Your first question comes from the line of (Peter Brooks). Please state the name of your organization. Your line is open.

(Peter Brooks): OK, I am retired. My question relates to duals – people who have Medicare and Medicaid. What happens as regards to the Medicaid portion?

Heidi Edmunds: Would Medicare be the primary payer or the secondary?

(Peter Brooks): Medicare would be the primary, Medicaid would be the secondary. And it would be in a new area which is coming up this year.

Heidi Edmunds: So, if you fall within a competitive bidding area, you would need to use a contract supplier.

(Peter Brooks): OK. And what about if it's pure Medicaid? What happens then? This happens to be Florida. Does the Florida Medicaid have to use a DMEPOS supplier, qualified?

Heidi Edmunds: So, this would not be the dual situation, which is the (other) ...

(Peter Brooks): No, this is another situation, yes.

Heidi Edmunds: OK.

(Peter Brooks): If you've got pure Medicaid – Florida Medicaid – do they have to use a DMEPOS supplier qualified by CMS? Absolute, I'm talking about.

Heidi Edmunds: OK, as far as absolute, I would definitely recommend checking with the state Medicaid office. I don't want to give improper guidance, since the guidance varies from state to state. So, definitely the Medicaid office would be the best guidance on that.

Peter Brooks: OK, thank you very much.

Heidi Edmunds: Thank you.

Operator: Your next question comes from the line of Joanne Thede. Your line is open. Please state the name of your organization.

Joanne Thede: Hey, this is Joanne from Aurora Pharmacy in Wisconsin, and I have a question with the supplier (influx) to be grandfathered. We currently do wheelchair rentals to our pharmacy, so when our areas come under the Competitive Bid, are there steps you have to take with CMS to be grandfathered, or if you are already are, you know, have so many months rental of a wheelchair into Medicare, you just continue but will only get, you know, the allowed rate as of July 1st?

Heidi Edmunds: OK. So, if you're going to continue – if you're going to become a grandfather supplier and that you're going to continue to rent, the requirement is that you have to rent to all Medicare beneficiaries – or, give the option to continue the rental agreements with all of your Medicare beneficiaries. You would continue to do that, you need to notify your beneficiaries that currently are renting from you with a 30-day written notification to each beneficiary that resides in the CBA and is currently renting competitively (bid) equipment from your organization.

Joanne Thede: And is that something like the form that's available on CMS's Web site or ...

Heidi Edmunds: Exactly, yes. That's the one that's available on the Competitive Bidding Implementation Contract at [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com).

Joanne Thede: OK. And I just have one other question when you talk about some stores, like with the diabetic testing strips, some of their prices could be different. I'm not sure I understand because won't the allowable for Medicare be the same no matter if you're walking into a store or doing mail order as of July 1st? I guess I don't understand that piece.

Heidi Edmunds: So, it's the issue of the accepting Medicare as assigned payment rate. So, the payment rate would be equivalent to our single payment rate. However, if they offer the beneficiary an ABN.

Joanne Thede: Oh, OK. You just need ...

Heidi Edmunds: Yes.

Joanne Thede: OK.

Heidi Edmunds: Exactly.

Joanne Thede: OK. Thank you.

Heidi Edmunds: Thank you.

Operator: Your next question comes from the line of (Reba Simmons), (Maryland County Medical). Your line is open.

(Reba Simmons): Yes, good afternoon. I'm wondering if supplier – if a Medicare provider who won a bid does not accept their bid, will the bidding be open for that particular area or that particular bid area for other vendors to bid over? Or is the bidding closed when you've given all the bids?

Heidi Edmunds: Yes, the bidding is closed for that.

(Reba Simmons): So, whoever accepts the bid, accepts the bid. So, if vendors do not accept their bid, then we'll have less – there'll be less providers or less vendors around providing that equipment.

Heidi Edmunds: OK. If this became an issue, we could always award additional contract.

(Reba Simmons): OK, that was the answer to my question. I have one more question. In terms in diabetic supplies, and I actually typed this question as well, because I want it to be clear. If you do not win the mail order for diabetic supplies, you can still provide diabetic supplies out of your store front if people come in to (purchase).

Heidi Edmunds: Yes. If they walk into your store front and purchase the supplies and the supplies are in no way delivered to their home by any means, yes, they can purchase it at your store.

(Reba Simmons): OK, thank you so much.

Operator: Your next question comes from someone's who's line is not transcribed and may have their phone on mute. If you queued up for a question, your line is open, please state your first and last name, and name of organization. Your line is open if you wanted to ask a question.

(KB): This is (KB). Can you hear me?

Heidi Edmunds: Not very well.

(KB): This is (KB). Can you hear me now?

Debby Yes. Ask your question, sir.

(KB): OK, I posted almost all my questions on the type the screen, on the screen, rather. So, I don't think I have too much to ask verbally. I did not know if I was going to get a chance to ask or not, so I kept on typing away. Last week, there was a presentation and I could not access it for whatever reason. I tried hard over and over again. Where can I find the presentation that they just posted somewhere?

Heidi Edmunds: So, what you should do is, in the chat box, send me your email address and I'll send it to you after the webinar.

(KB) OK, thank you.

Heidi Edmunds: You're welcome.

(KB) And how do ...

Operator: Oh. Your next question comes from the line of Joanne Thede, Aurora Pharmacy, Inc. Your line is open.

Joanne Thede: OK, just trying yet to understand the diabetic supplies. So, if we're not a mail order and we're a retail pharmacy and a customer would come in, if we bill Medicare, we have to accept the rate as of July 1st. But you're saying we do have the option of having the customer sign an ABN and then it would be like a cash-only sale?

Heidi Edmunds: OK. So, are you a Medicare participating supplier where you accept assignment?

Joanne Thede: We're a non-par.

Heidi Edmunds: OK.

Joanne Thede: I'm just trying to understand where signing the ABN could be used.

Heidi Edmunds: OK, I was just verifying that. If you're a non-participating supplier, you can present the beneficiary with an ABN, for the difference in price.

Joanne Thede: And we could still bill to Medicare to get what they paid, and then have the customer sign an ABN for the difference?

Heidi Edmunds: Yes, you may.

Joanne Thede: Well.

Donna Cupina: Does that answer your question?

Joanne Thede: Yes, it did.

Donna Cupina: OK, thank you.

Operator: Your next question comes from the line of (Reba Simmons), (Maryland County Medical). Your line is open. (Reba Simmons), your line is open.

(Reba Simmons): Hello? Thank you. Can you hear me now?

Female: We can.

(Reba Simmons): OK. The question is what about new Medicare providers who are not Medicare providers yet, who have not put in a bid, how will that affect the Medicare providers like us who have possibly want to bid or who are waiting to hear if we want to bid? Will they just be able to come in, apply for Medicare provider status, and then bid?

Heidi Edmunds: Yes, the competitive bidding program is only available to currently Medicare providers.

(Reba Simmons): Yes.

Heidi Edmunds: So, if you're waiting to bid, that will be soon; that will be announced soon. But otherwise, you're eligible to bid in future rounds.

(Reba Simmons): And what is the next round? So any new provider will have to wait for the next round.

Heidi Edmunds: For that area, yes. The rounds are – specific, yes.

(Reba Simmons): OK. OK. Thank you.

Heidi Edmunds: You're welcome.

(Reba Simmons): While we're on that topic, when will winners find out if they were winning the bid for this round?

Heidi Edmunds: That will be very soon.

(Reba Simmons): And how will they be notified?

Heidi Edmunds: They are sent a FedEx package when that's sent out.

(Reba Simmons): Thank you.

Operator: Your next question comes from the line of (Naomi Cottoms), Tri County Rural Health. You're line is open.

(Mary Elizabeth): Hello, this is (Mary Elizabeth) from Tri County Rural Health Network and we are a non-profit organization. I just wanted to comment and say that through the mail order organization, we see citizens that have Medicare and Medicaid; sometimes Medicaid is primary. Then when they go to a store front and probably receive diabetic supplies, they can also through mail order receive their needles; whereas in a store front they will have to pay cash. But if they do it through mail order, it will be billed Medicare or Medicaid, whichever is primary. That was just a comment.

Donna Cupina: Thank you.

Heidi Edmunds: OK. And can I jump in really quick on the question from Joanne Thede from Aurora Pharmacy?

Donna Cupina: Sure.

Heidi Edmunds: OK. We were following up on that behind the scenes. You would actually – we are going to give out further guidance on this, but you would actually not

use an ABN, you would merely bill the beneficiary. But we will be giving clarifying guidance on this in the future.

Female: Thanks, Heidi.

Donna Cupina: Thanks, Heidi.

Operator: Your next question is a follow-up from (Reba Simmons). Your line is open.

(Reba Simmons): Yes, this is a question about delivery rule. You can usually deliver a walker and a wheelchair 48 hours to the facility. Will those same rules apply, for example, if we're in Maryland and we're delivering to West Virginia? Do we still have to – can we still deliver 48 hours or after the patient gets home? Or will those rules change?

Heidi Edmunds: I'm going to have to get back to you on that question. Can you submit that question via email to the call?

(Reba Simmons): Yes.

Heidi Edmunds: Thank you, (Reba).

(Reba Simmons): Through Q&A?

Heidi Edmunds: Yes.

(Reba Simmons): OK.

Operator: Your next question is a follow-up question from a gentleman. Please state your name. Your line is open.

(KB): (KB). Can you hear me?

Female: (Email address).

Donna Cupina: Yes, we can.

(KB): Oh, thank you. You know, just to follow up on a gentleman who was talking about Medicare and Medicaid this year that's coming up, I think he was

talking about HMO. If that is true, that's what I need to know, because how does that affect – you know, they are talking about Medicare and Medicaid combined together in HMOs. How will that affect competitive bidding?

Heidi Edmunds: OK, so your plan would notify you directly. But any questions you have outside of any notifications you've received, you would definitely want to contact your plan directly to see what the affect would be.

(KB): OK. And also n the same note, right now, quite a few patients are enrolled in the HMO, Medicaid patients. How does that affect them, the competitive bidding? How does that affect them?

Heidi Edmunds: Yes, it would be the same answer. Other than any communication you receive directly from your plan, this plan does not affect it. However, I would definitely always verify that directly with your plan in case a mailing got missed, et cetera.

(KB): Thank you very much.

Heidi Edmunds: Of course, thank you.

Operator: Your next question comes from the line of (Diane Waley), (HIVAP). Your line is open.

(Diane Waley): Hello, thank you. Can you speak to the issue of patient protections and quality control? In the past, we've heard reports about low cost Medicare equipment suppliers who've delivered wheelchairs that don't fit, walkers that would be inappropriate and so on, things that are unusable by the beneficiary. Can you speak to what issues are in place to assure that the low bidder provides quality care and supplies?

Heidi Edmunds: Those protections that are available to all of the Medicare beneficiaries are still in place; however, if there is a situation such as that, we would definitely encourage you to contact 1-800-Medicare to report it, so that we can become aware of this.

(Diane Waley): Thank you.

Heidi Edmunds: And as an additional comment, all of the products provided are FDA approved products.

(Diane Waley): Yes; it still would need to fit and be appropriate for the beneficiary. Something that's ...

Heidi Edmunds: Absolutely.

(Diane Waley): ... too large or too small would – thank you.

Heidi Edmunds: Yes, absolutely. But if you definitely call 1-800-Medicare to report this so we can have a detailing account of this. We've been unaware of any complaints such as this.

(Diane Waley): Thanks.

Heidi Edmunds: Thank you, and thank you for being our eyes on the street for this.

Walter Gutowski: And this is Walter Gutowski in the Office of Communications. I wanted to point out also on that last question that there is a document on the DMEPOS tool kit that I referenced earlier which refers to this beneficiary protections with regard to DMEPOS equipment. It is a program preview document from April of 2010, but we are updating that now. It's pretty much essentially the same now as it was then; so if you want to look at something quickly to see what kind of safeguards are afforded, that's a good document you can start to look at.

Debby: Awe possted the URL for the DMEPOS tool kit in the chat Q&A box, on the left-hand side of your screen, so you can go there for the DMEPOS tool kit.

Operator: We have another follow-up question from the line of (Reba Simmons), (Maryland County Medical). Your line is open.

(Reba Simmons): I'm sorry – for the – I can't remember what slide it is, but there was something specific in competitive bidding that says if a doctor prescribes a specific type of cushion or brand of cushion, that it was up to us to either furnish that piece of equipment or find something that I guess is comparable.

If we cannot furnish that piece of equipment because, of course, with competitive bidding we're getting paid less, so it's going to be much harder to provide those higher end items. Can we – do we refuse it, will we get reprimanded for refusing it, do you know what I mean? Because there are some specific rehabs that only like to use a specific product. So, is that going to work against us? Or is that going to shine a bad light on us as DME companies if we do not provide what they specifically requested.

Heidi Edmunds: OK, yes. So, following back up on that list, there are three options are to, A, provide the item; B, work with the physician to find an acceptable item that the physician agrees will meet the needs of the beneficiary; or the third option is to find another contract supplier who will provide that item.

(Reba Simmons): Correct.

Heidi Edmunds: But it is a term of the contract. So, yes, there would be a ...

(Reba Simmons): Wow. OK, thank you.

Operator: There are no further questions at this time. I'll turn the call back to our presenters.

Donna Cupina: I have two quick ones from the chat. So, if a supplier won a bid for oxygen but not wheelchair, can they be contracted supplier for oxygen and grandfathered supplier for wheelchairs?

Heidi Edmunds: If they are currently renting to that beneficiary at the time of competitive bidding, they would have to agree to be grandfathered supply for all Medicare beneficiaries, then they could. If they were not already renting to that supplier and it was a new order, then no. They would need to go to a contract supplier for both the oxygen and the wheelchair. Did that answer it?

Debby: Yes, it does; thank you.

Female: OK, thank you.

Donna Cupina: OK, thank you very much Heidi and Walt. We appreciate it. We'll move on and our next speaker is Jim Lyon, and he's going to talking about an overview of Indian health care.

Jim Lyon: Good afternoon and thank you for having me this afternoon. Today, I'm going to be talking a little bit about just Indian people in general, a little bit about the Indian health system, and then wrap up with a description of some of the CMS roles in Indian health. First of all, I wanted to point out that the Indian people are an ethnic – they are ethnically diverse people covering people from the Florida Everglades to the Desert Southwest to the Woodland Coasts and all the way up into Alaska.

So, they don't have a single cultural society, so there's nobody that's really an expert on Indian people. However, I want to point out some of the different characteristics as we move throughout my presentation. There are 566 federally recognized tribes and about a half again as many state-recognized tribes with about 250 different language groups actively spoken. And with each one of those different language groups, there is a different culture and (mores) that each of the tribes have.

Each tribe has different customs and taboos. There are tribes that no longer recognize you as being Indian if you leave the reservation. Some tribes, a woman loses her tribal membership if she marries outside the tribe. Many tribes in the Southwest have incorporated a lot of Catholicism into their tribal culture. And so, there are some of them that you can't even reside on the reservation if you weren't married in the Catholic Church.

Some tribes are matriarchal, and there are other tribes that women can't even vote in the tribe. Some of the smaller tribes are losing their language and that is something that is happening world-wide in indigenous people, that small tribal groups are losing their language. The last tribe that I remember losing their language was probably four or five years ago and that was the Kwapa tribe in Northeast Oklahoma, where the last speaking member of that tribe passed away.

Approximately 60 percent of Indians live in urban areas, and a lot of that has to do with back in the 1950s when the federal government wanted to integrate Indian people into the mainstream society so there were programs which encouraged Indians to be relocated to large metropolitan areas like Los Angeles and Chicago, New York City, Detroit, Denver, and Seattle.

Some people ask us what they should call us, what should they call us, should they call us Native Americans, American Indians, Indigenous Americans. But my recommendation always is to call us by our tribe, either Navajo, Cherokee, Sioux, Lakota, Shoshone, and I think a lot of other Indian peoples will recognize that as something that's appropriate.

Recognition as an Indian requires being recognized by your tribe and so if you're not recognized by your tribe, then generally you're not viewed really by Indian people as being Indian. Generally, to be recognized by your tribe, you have to have some record of tribal membership, either your parents, grandparents, or other ancestors need to be Indian. And a lot of tribes, you have to live in that general area and maintain close social ties with your tribe.

There are about 5 million people that identify themselves as being at least part American Indian or Alaskan Native in the United States. Approximately 1.6 million of those are served by the Indian Health Service. And now I'll move on to some of the tribal government aspects. Tribal governments are responsible for everything that occurs within the reservation; they have to deal with many of the same issues that state governments deal with.

They have to deal with every department of the federal government, the department of transportation – they have roads throughout the reservations; housing and urban development, they work with them – reservation housing, all the buildings on the reservation. Education, their schools on the reservations, there's schools, there's small colleges on many of the reservations. Department of Justice, there are jails and police forces, court systems, the Department of Homeland Security; many of the reservations are on the U.S. borders and deal with border issues.

Environmental Protection Agency, the Department of Interior – actually the Bureau of Indian Affairs is under the Department of Interior. But there are also forests on the reservations, wildlife, hunting. The largest reservation in the United States is the Tohono O'odham Reservation which is in southern Arizona and much of that reservation extends down into Mexico. The largest reservation that's wholly in the United States is the Navajo Reservation in the Four Corners area of New Mexico, Arizona, Colorado and Utah, which – and the Navajo Reservation is approximately the size of West Virginia, so it's about four times the size of the state of Maryland.

The federal responsibility to provide health care is based on treaties. Between 1778 and 1871, more than 400 treaties were entered into between the U.S. . government and Indian tribes; and prior to that, there were several other hundred treaties that were entered into with England, Spain, and France. The Indian tribes exchanged over 400 million acres of land to the U.S. government, and many of the treaties contained provisions which explicitly included promises to provide healthcare. In 1803, the war department assumed responsibility for Indian healthcare, and then later on in 1849, the Department of Interior was assigned the responsibility for health care and one branch within that Department of Interior was renamed as the Bureau of Indian Affairs.

In 1954, the responsibility of health care was transferred from the Department of Interior over to the Department of Health and Human Services, and the Indian Health Service was created. The federal trust responsibility is – however, has never been the sole responsibility of the Indian Health Service and is a shared responsibility across the federal government, even though the Indian Health Service serves as the primary agency with leadership in Indian health. Many of our sister agencies also work closely with tribes and Indian people. For example, SAMHSA provides millions of dollars in contracts and grants for behavioral health.

AOA – there are senior centers across many of the reservations or most of the reservations, senior programs. The Health Resources and Services Administration provides assistance with health professional shortage areas, professional recruitment with National Health Services, core pay back

scholars; they also provide technical assistance on health IT for rural areas. They provide funding for both urban and rural clinics. The Administration for Children's and Families provides funding for Head Start programs, child care, (TANIF), the low income heating and energy assistance programs, child support, family and youth services.

CDC provides epidemiology services, and they also provide the vaccines for children's program and also provide funding for the breast and cervical cancer programs. And then CMS works with the IHS tribal and urban Indian health programs, particularly in reimbursement for Medicare, Medicaid accreditation and beneficiary services. The Indian Health Services is an agency within this Department of Health and Human Services; however, an interesting thing is that as you might recall, I just said that they were originally under the Department of Interior and so they still get their funding through the Department of Interior, not through the Department of Health and Human Services.

(I'll) just – and there are discretionary programs in there. The Indian Health Service itself is one of the largest healthcare systems in the country. They are divided into 12 areas or regions; they have – the Indian Health System itself is divided primary into Indian Health Service, tribal and urban Indian programs, and oftentimes, you might hear them referred to as ITU programs. There are about 45 hospitals, over 600 ambulatory care centers. The tribal programs also operate nursing homes, dialysis centers, school based clinics, home health agencies and regional youth treatment centers.

The urban Indian programs are located in large metropolitan areas for the most part and they offer primarily ambulatory case services and sometimes referral services. The Indian Health Service itself operates direct care services and some behavioral health treatment programs. They don't offer – the don't normally – well, they actually don't operate any nursing home, even though they were given the authority to operate – we (at least receive) reimbursement for nursing homes, the Indian Health Service itself does not operate any nursing homes at this time.

Under the Indian Healthcare Improvement Act in 1976, the link between CMS and the Indian Health Service was established when the Indian Health Service was given the authority to bill and collect for Medicare and Medicaid services. And the Medicare and Medicaid revenue that's generated by their health care programs are now an important part of their budget. Some of their programs' budgets are now supported for anywhere from about 15 to 65 percent by reimbursements from Medicare and Medicaid. So CMS is a key component of the federal trust responsibility.

Any changes in our policies, our CMS policies and programs make a significant difference on Indian Health projects and programs. And with – and CMS not only covers the Indian Health Service itself, their reimbursements, but as you may recall I said that the Indian population across the country is about 5 million; IHS, the Indian Health Service, serves about 1.6 million. And so we look at CMS – we look at the entire Indian population across the country; about 60 percent of the Medicare and Medicaid reimbursements for Indian people go to either the Indian Health Service, Tribal or Urban Indian Clinic programs; however, or to the states where those programs – or state programs where there is a reservation entity.

So, about 30 to 35 percent of the reimbursements made for Indian health – Indian patients are in states where there is no reservation. There are about 180,000 Medicare beneficiaries that are served by the Indian Health Service, about also 800,000 Medicaid beneficiaries and about 30,000 CHIP beneficiaries.

The Medicare and Medicaid reimbursements to the Indian Health Service itself exceed \$800 million a year. So, what CMS says is we try to help the IT use system in maximizing their access to Medicare, Medicaid, and CHIP; and we do that through a number of ways.

First of all, within CMS, we have a tribal affairs group that serves as the liaison between CMS and tribal communities and other federal programs. We also at each one of our regional offices, we have a Native American contact who is available to provide technical assistance to tribal programs. And then in partnership with the Indian Health Service, the state, the (SHIPS), the

Social Security Administration, and the VA, we hold outreach and education events across Indian country.

Last year, we held 18 of these outreach and education events that were attended by Indian beneficiary advocates that's sometimes called benefits coordinators or community health representatives. And we had participants ranging from about 15 in some of the – some of our events up to about 150 participants.

We also produced what we call the Medicine Dish series, which is a series of broadcasts for health professionals and the American Indian and Alaskan Native beneficiaries on CMS programs. And we broadcast those Medicine Dish programs on You Tube, and they are also available online through the NIH. There are – those Medicine Dish programs area available on our CMS Web site.

And in addition to these, we also have all tribes' calls where we provide technical listening sessions and solicit input from tribes on CMS policy impacting American Indian and Alaskan Native beneficiaries and the operation of Indian Health Programs. And we provide tribes the opportunity to hear about CMS programs from subject matter experts.

Sometimes, we have – we encounter some barriers to outreach for Indian people, and many of those barriers are the same that we encounter with any of our beneficiary populations. Some of those would be geographic barriers where we – most reservations are located in remote or frontier areas, and then we also have a language barrier where a lot of our seniors still may be primarily – speak the language of their tribe. And many of the Indian languages are only spoken languages, so they're – so there's no way to get them written material.

And some of the languages that are written have been only written for the last 30 years or so, so if you're trying to target seniors, the seniors may know English, be able to read English better than they can read their own language since there wasn't a written language. One additional barrier to outreach that Indian people have that other groups may not have and that is the federal trust

responsibility. A lot of times Indian people, particularly our seniors, don't feel it's their responsibility to apply for Medicaid or any other – or even Medicare, even if they qualify for Medicare.

They may not feel that they should access through services through Medicare or Medicaid because of the federal trust responsibility and because of the exchange of land and other resources for healthcare services. Do you want me to answer (inaudible)?

Donna Cupina: Jim, we do have a question. What is the ITU?

Jim Lyon: An ITU is how we a lot of times refer to the Indian Health System and the ITU stands for Indian Health Services, which is the federal component of the Indian Health System, the T is the Tribal and the U is the urban health. And they're different – they are basically completely programs. In 1976, under the Indian Self-Determination Act, Indian tribes were given the authority to assume the administration of health care programs from the Indian Health Service, if they chose to do so. And so many tribes have opted to do that and so – about half of the Indian Health Service funding is now operated by tribes themselves.

Donna Cupina: And you said that long term care and support delivered to tribal elders – Indian Health Care doesn't have nursing homes; does that mean the majority of care is provided by family members at home.

Jim Lyon: There is a lot of care provided by family members at home, there are actually quite a few tribal nursing homes. There are about I think 14 tribal nursing homes and there are a lot of Indian people that are in mainstream nursing homes as well.

Donna Cupina: Thank you. (Beth), can you please open it up for other questions for Jim?

Operator: If you would like to ask a question at this time, star one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Your first question comes from the line of Judith Bendersky from Alaska SHIP. Your line is open.

Judith Bendersky: Thank you. Can you hear me?

Donna Cupina: We can.

Jim Lyon: Yes, ma'am.

Judith Bendersky: OK, great. So, some – I understand that there was some change in federal law, either the Indian Health Care Improvement Act or more recently that enables tribal health facilities or tribal corporations to purchase Medicare premiums for their beneficiaries; both part A, if a person didn't work, part B and part D premiums. Are you familiar with what law or statute made that possible? We do have some entities in Alaska doing that, and a few others doing that.

Jim Lyon: That's something that we'll have to get back with you. There has been in the past some provisions allowing tribes to purchase the Medicare premiums or be the beneficiary payers on those premiums. And with the changes, we'll have to get back with you on the specifics of the changes themselves.

Judith Bendersky: All right, thank you.

Jim Lyon: All right, thank you, Judy.

Operator: If you wish to ask a question, star one on your telephone keypad. I do have another question, I do not have a name, so please state your name prior to asking your question. Your line is open.

(Peg Newton): This is (Peg Newton). Am I on the line?

Donna Cupina: We hear you.

(Peg Newton): OK. I did state my name before, but that's OK. I wanted to mention I also would be interested in that specific law allowing the tribes themselves to do the MSPs. But I was wondering if you could speak a little bit, too, about the value to Indian Health Service and the clinics of doing outreach so that tribal members who would qualify for the buy in programs can actually assist their tribal community by getting onto those programs.

Jim Lyon: Sure. And you can – as I mentioned, for any of the individual IHS facilities, anywhere from 15 to 65 percent of their budgets are derived from Medicare and Medicaid reimbursements. And so, the more they outreach the individual IHS or tribal facilities, the more they outreach to their beneficiaries, the more reimbursements they are going to be able to receive and the more services they'll be able to provide.

And so, sometimes people – sometimes there are programs that look at it where if they enroll a person in Medicaid, maybe that person's going to go down the street to receive services instead of the Indian Health Service facility. However, generally if you look at the services provide at Indian Health Service facilities, there is no shortage of beneficiaries coming through the doors, and so they – the more of them that want to come in there and receive services the better.

When I was the CEO of a hospital with the Indian Health Service in New Mexico, we did a study to identify where our patients were and where they were going and why we weren't able to get some of the patients in. And at that time, back in the early 2000s, about 42 percent of Medicaid beneficiaries were going to providers outside of our facility. And so, we actively entered into quality programs like the Malcolm Baldrige program to actually improve the quality of services within our facilities.

Peg Newton: Well ...

Jim Lyon: And it ...

(Peg Newton): I'm sorry the reason I was I was mentioning it for others on the call, who may not have been aware of it, is often the funding received from Indian Health Services to the clinics is, you know, capped at a certain amount that doesn't last through the year. And so, the more that outside sources like Medicare and Medicaid can be tapped and provide inflow, the more the funding remains for people who have, you know, don't qualify for those other benefits.

Jim Lyon: Well, that's correct. The funding for Indian Health Service is basically broken out into two funding sources – one is for direct services, where they can serve

any patients that are coming through the doors; the other one is called contract health services, which is a capped funding source. And those are for services where the Indian Health Service has to refer patients out of their facilities to private providers. And those funds do generally run out before the end of the fiscal year; and so sometimes you'll hear in Indian populations that you don't want to get sick after about July 1st, because then you are not going to be able to be referred out.

And so if a beneficiary is on Medicare or Medicaid, if the beneficiary is on Medicaid, there is not co-payment for them or coinsurance, and so generally they can be referred out to any provider they want to be referred out to that accepts Medicaid beneficiaries. For Medicare beneficiaries, even though a lot of seniors don't feel that they need part B services, we always recommend that they go ahead and sign up for those Part B services when they are eligible to because it gives them option.

If they need to go out for, say, cataract surgery then they are going to be able to go out for their cataract surgeries when they need to or other services that the Indian Health Service isn't able to provide in house. And also, when those patients do sign up for Medicaid or access to their Medicare services, it does extend the dollars that are available through the Indian Health Services contract health services budget.

(Peg Newton): OK, thank you.

Operator: Your next question is a follow-up from Judith Bendersky, Alaska SHIP, Your line is open.

Judith Bendersky: Thank you. Yes, we have lots of health corporations that actively enroll elders in Medicare. There are alternate health resource counselors, or financial patient assistants that actually go (snow machine) from house to house to enroll people in everything and anything that they're eligible for. And that is because there is a policy of that health corporation, let's say, the Yukon-Kuskokwim Health Corporation is very proactively involved in enrolling people or assisting them to enroll.

Other corporations – well for instance, the Alaskan Native Medical Center, upon admission or registration, they basically tell people that they can't be admitted until they've enrolled. And other corporations don't seem to care or they've made a conscious decision that in respect of the Indian Self Determination, the person can do what they choose.

So, does the Indian Health Care Improvement Act that you mentioned (trump) what a regional corporation says? Or, you know, I just – there seems to be a rub in where people where call our (SHIP) and say, do I have to enroll? And I basically feel that it's ethical to push them back to their own tribal corporation to make that decision. What do you recommend?

Jim Lyon: That's what I would recommend also is to refer them back to their own health care center. However, there – under federal law, it's a requirement for the beneficiary to apply for those alternate resources if they are possibly eligible for them. And that they ...

Judith Bendersky: OK. And that's the law that – oh, I'm sorry, go ahead.

Jim Lyon: And that they – and that's under 42 CFR 136.51, I think.

Judith Bendersky: OK, excellent. Thank you.

Jim Lyon: It's somewhere around there, at least. It's ...

Judith Bendersky: OK.

Jim Lyon: I mean 136.23 and 51. And it's a – their alternate resource requirement that they – the Indian – and it also talks about the Indian Health Service being the payer of last resort, but it also – there's also a requirement for beneficiaries. And that's – so it's talking about contract health services and the use of contract health services. And so, before the Indian Health Service or the tribe can use their contract health service dollars, the beneficiary has to apply for those eligible programs.

Judith Bendersky: Excellent. Thank you.

Jim Lyon: You're welcome.

Operator: There are no further questions at this time. I'll turn the call back to our presenters.

Donna Cupina: Thank you very much, Jim; appreciate it. Again, thank you for joining us today. But we want to make sure that we are meeting your learning needs, so before you disconnect, we have a few questions for you. We would really like to get your feedback, so please take the time and answer. There are only three questions, and they will show up on the screen now. And it will be one question at a time.

So, the very first question is how will you share this training with others who counsel people who use CMS programs? So, if you would please place your answer now. And then we'll move on to question two. The second question is how many people will you share the information with? And the last question is, how helpful is the information provided in today's webinar.

OK, so if you didn't get an opportunity to ask any additional questions, you can email them to us at [training@cms.hhs.gov](mailto:training@cms.hhs.gov) or [SHIP@cms.hhs.gov](mailto:SHIP@cms.hhs.gov). We do want to say that the call was recorded and both the transcript and the recording will be posted on the NTP Web site in about a week. Our next call is scheduled for March 5th, and we look forward to speaking with you again soon. Thank you.

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

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