



**CMS 2010 BI-REGIONAL MEDICARE HEALTH PLAN COMPLIANCE
CONFERENCE**
Boston & New York – Serving Our Beneficiaries Together

Verbatim Transcript

Best Available Evidence and Limited Income Newly Eligible Transition Program (Limited Income NET)
Rosemary Ucaner, Linda Sheo, and Debra Smith

>> HELLO. MY NAME IS
ROSEMARY UCANER,

AND I WORK IN THE CUSTOMER
RELATIONS BRANCH AT CMS HERE

IN THE NEW YORK REGIONAL OFFICE.

I WOULD LIKE TO INTRODUCE
DEBRA SMITH AND LINDA SHEO.

MS. SMITH HAS WORKED FOR THE
CMS FOR MORE THAN 35 YEARS.

HER EXPERIENCE IN THE
MEDICARE PROGRAM IS VARIED

AND EXTENSIVE.

SHE HAS ACTIVELY BEEN INVOLVED
IN ALL FACETS OF THE MEDICARE

PROGRAM, INCLUDING
MEDICAL REVIEW, BENEFICIARY

AND PROVIDER OUTREACH,
MEDICARE SECONDARY PAYER,

AND ADMINISTRATIVE
LAW JUDGE DECISIONS.

SHE IS CURRENTLY THE REGION
2 END-STAGE RENAL DISEASE

COORDINATOR, AND NATIONALLY
RECOGNIZED AS THE MEDICARE

ESRD POLICY SPECIALIST.

SHE IS ALSO AN OUTREACH
COORDINATOR AND TRAINER

FOR THE NEW YORK REGIONAL
OFFICE IN PARTS A, B, C, AND D.

MS. SHEO IS THE LEAD
CASEWORKER FOR CMS NEW YORK

REGIONAL OFFICE.

HER MEDICARE EXPERIENCE
INCLUDES FINANCIAL MANAGEMENT,

POLICY, CLAIMS PROCESSING,
AND APPEALS.

WELCOME, DEBRA AND LINDA.

[APPLAUSE]

>> OK. ALL RIGHT.

I JUST WANT TO MENTION BEFORE
WE GET STARTED THAT--

HAS EVERYBODY PULLED OFF THE
PRESENTATION OFF THE WEB SITE?

NO. OK, WELL, THAT'S GOOD
BECAUSE I WAS GONNA TELL YOU

THE ONE THAT WAS ON THERE LAST
WEEK WAS CHANGED AT THE END

OF THE WEEK.

SO I WAS GONNA TELL YOU,
WHEN YOU GO BACK TO YOUR

OFFICES, YOU CAN PULL DOWN AN
UPDATED ONE, BUT SINCE YOU

DON'T HAVE IT, IT DOESN'T
MAKE A DIFFERENCE.

OK. ALL RIGHT.

DOES ANYBODY KNOW WHAT
BEST AVAILABLE EVIDENCE IS?

I'M GONNA MAKE THIS A LITTLE
MORE INFORMAL SO WE CAN TALK.

HAS ANYBODY HEARD THE CONCEPT
OF BEST AVAILABLE EVIDENCE?

YES. HAVE YOU WORKED WITH IT?

YES. OK.

HAS ANYBODY ELSE HEARD
OF BEST AVAILABLE EVIDENCE, BAE?

YES. OK. OH!

THANK YOU, MR. SLATON.

YES. OK.

BASICALLY WHAT'S GOING ON HERE
IS WE HAVE SITUATIONS WHERE

THERE IS CERTAIN INFORMATION
THAT WE'RE GETTING FROM THE

STATE THAT UPDATES OUR RECORDS
SO THAT WE HAVE THE CORRECT

INFORMATION AND INDIVIDUALS
WHO ARE IN YOUR PLANS ARE ABLE

TO GET THEIR DRUGS AT
THE RIGHT COPAY LEVEL.

OK, SO ON THE FIRST SLIDE,
WE'RE JUST GIVING YOU A LITTLE

BIT OF THE BACKGROUND THAT WE
RELY ON THE ELIGIBILITY FILES

FROM THE STATE AND SOCIAL
SECURITY TO ESTABLISH THE

INDIVIDUAL'S LOW-INCOME
SUBSIDY,

THE DEEMED ELIGIBILITY,

AND THE APPROPRIATE
COST-SHARING LEVEL.

BUT IN CERTAIN CASES,
CMS SYSTEMS DO NOT REFLECT

THE RIGHT INFORMATION.

AND THIS MAY OCCUR BECAUSE THE
INFORMATION FROM THE STATE DID

NOT COME OVER CORRECTLY,
OR THERE MAY BE SOME ISSUE

THAT THE INFORMATION IS NOT

AVAILABLE, SO THAT THE BAE

POLICY IS USED WHEN THE LOW-
INCOME SUBSIDY INFORMATION

IN THE PLANS AND CMS' SYSTEMS
IS WRONG OR IS NOT CORRECT.

ALL RIGHT.

SO WE'RE USING THE BEST
AVAILABLE EVIDENCE TO CORRECT

THE LOW-INCOME SUBSIDY, AND
IF ANYBODY DOES NOT WHAT

AN ACRONYM IS, PLEASE
JUST RAISE YOUR HAND,

BECAUSE THE GOVERNMENT IS VERY--
THEY USE A LOT OF ACRONYMS,

AND WE DON'T ALWAYS
KNOW WHAT THEY ARE.

SO THE LIS IS
LOW-INCOME SUBSIDY.

NOW, AGAIN, THE BEST AVAILABLE
EVIDENCE, WHAT THAT ALLOWS IS

IT ALLOWS THE BENEFICIARY
ACCESS TO PART D DRUGS

AT A LOWER COST-SHARING LEVEL
OR ZERO COST-SHARING LEVEL IF

THE BAE ALSO VERIFIES
THE BENEFICIARY'S

INSTITUTIONAL STATUS.

IT ALSO INCLUDES A PROCESS TO
CORRECT THE BENEFICIARY'S

LOW-INCOME STATUS AND PLANS IN
CMS' SYSTEMS, AND THIS INVOLVES

AN ACTION BETWEEN THE
PART D PLANS AND CMS.

HOW DO THE BEST AVAILABLE
EVIDENCE REQUESTS REACH

THE PLANS?

AND WE LAID IT OUT VERY
CLEARLY SO THAT WE ALL SEE HOW

IT'S COMING BECAUSE I KNOW

THERE'S A LOT OF DIFFERENT
INFORMATION AROUND.

FIRST OF ALL, THERE'S
THE DIRECT CONTACT.

A BENEFICIARY CALLS YOU.
A PHARMACY CALLS YOU.

OR YOU GET IT IN THE CTM.

THAT'S THE COMPLAINT-TRACKING
MODULE.

AND THAT COULD BE FROM
A REGIONAL OFFICE.

IT COULD BE FROM A SHIP.

THE STATE HEALTH INSURANCE
PROGRAM COUNSELORS, THEY HAVE

ACCESS--I THINK PAUL MENTIONED
BEFORE HE WAS TALKING

ABOUT THE SHIPS HAVING
ACCESS TO PUT COMPLAINTS

INTO THE CTM.

OR YOU MAY GET IT
FROM 1-800-MEDICARE.

NOW, STEP ONE, AND WE PUT IT
OUT THERE: YOU HAVE TO ACCEPT

ONE OF THE ESTABLISHED FORMS
OF THE BAE EVIDENCE TO SHOW

THE DEEMED STATUS.

DEEMED STATUS IS ALWAYS
REFLECTING A STATE--SOME KIND

OF STATE ACTIVITY, STATE
ACTION--INSTITUTIONAL STATUS,

OR IF THIS PERSON IS GETTING
THEIR EXTRA HELP THROUGH

SOCIAL SECURITY, THEN THERE
IS SOME KIND OF AWARD LETTER.

SO IT'S THE LOW-INCOME SUBSIDY
THROUGH SOCIAL SECURITY.

NOW, WE LISTED A LOT
OF INFORMATION.

THAT'S WHY I'D LIKE YOU TO GET
A COPY OF THIS WHEN YOU GET

BACK TO YOUR OFFICES, BECAUSE
WE VERY CLEARLY PUT DOWN,

AND YOU PROBABLY HAVE IT
ALREADY IN YOUR OFFICES,

WHAT'S ACCEPTABLE,

WHAT'S ACCEPTABLE BEST
AVAILABLE EVIDENCE.

ALL RIGHT?

AND WHAT WE'VE DONE IS WE'VE
BROKEN IT UP INTO WHAT WE'RE

LOOKING FOR WHEN WE'RE
LOOKING FROM THE STATE--A COPY

OF THE BENEFICIARY'S MEDICAID
CARD THAT INCLUDES HIS OR HER

NAME AND THE ELIGIBILITY DATE
DURING A MONTH AFTER JUNE

OF THE PREVIOUS CALENDAR YEAR.

A COPY OF A STATE DOCUMENT
THAT CONFIRMS ACTIVE MEDICAID

STATUS DURING A MONTH
AFTER JUNE OF THE PREVIOUS

CALENDAR YEAR.

A PRINTOUT FROM THE STATE
ENROLLMENT FILE SHOWING

MEDICAID STATUS DURING A
MONTH AFTER JUNE THE PREVIOUS

CALENDAR YEAR.

IT COULD BE A SCREEN PRINT
FROM THE STATE'S MEDICAID

SYSTEM SHOWING MEDICAID STATUS
DURING A MONTH AFTER JUNE

OF THE PREVIOUS CALENDAR YEAR.

AND OTHER TYPES OF
DOCUMENTATION SHOWING

THE SAME STATUS.

NOW, WE HAVE BROUGHT COPIES
OF ACCEPTABLE BEST AVAILABLE

EVIDENCE HERE THAT
WE'VE RECEIVED.

WE FIGURED IF WE GAVE IT OUT
AND SHOWED YOU IT, THAT MIGHT

BE SOMETHING THAT WHEN YOU
SEE IT, YOU'LL RECOGNIZE IT.

YEAH. CAN YOU PLEASE--
THANK YOU VERY MUCH.

WE'VE GOTTEN A LOT OF
QUESTIONS FROM OUR SHIP

COUNSELORS BECAUSE THEY
ARE--WHEN THEY WORK WITH THE

BENEFICIARIES, THEY'RE SEEING
A LOT OF COPIES OF COUNTY

EVIDENCE NOT DIRECTLY FROM NEW
YORK STATE--ALBANY--BUT FROM

THE COUNTIES, THE VARIOUS
DEPARTMENT OF SOCIAL SERVICES,

AND THEY WANT TO KNOW
WHAT'S ACCEPTABLE.

BASICALLY, WHAT YOU HAVE TO
LOOK FOR IS YOU HAVE TO LOOK

FOR A DATE.

YOU HAVE TO SEE WHERE IT SAYS,

THIS PERSON HAS
THE MEDICAID ELIGIBILITY.

ALL RIGHT?

EFFECTIVE WHAT DATE?
OR HOW LONG?

YOU HAVE TO SEE WHETHER OR
NOT--OR WHAT IT SAYS IN TERMS

OF THE COPAY LEVEL.

ALL RIGHT?

AND YOU'LL SEE THERE'S
DIFFERENT INFORMATION.

THESE ARE REALLY--MOST OF
THEM ARE STATE PRINTOUTS.

NOW, IT'S POSSIBLE THAT WHAT
YOU MAY SEE FROM A MEDICARE

BENEFICIARY MAY NOT BE
THIS STATE PRINTOUT.

IT MAY BE SOMETHING ELSE,
AND I THINK THERE'S ONE OR TWO

THINGS IN THERE THAT SHOW
SOMETHING THAT THE MEDICARE

BENEFICIARY RECEIVED.

IT WAS A LETTER FROM THE
COUNTY STATING THAT THIS

PERSON HAD THE MEDICAID
STATUS, EFFECTIVE

A CERTAIN DATE.

THAT IS EVIDENCE THAT
THAT PERSON IS DEEMED.

NOW, WE DIDN'T INCLUDE IN
THIS, BECAUSE WE'RE NOT UP

TO IT YET,
BUT ANOTHER THING WOULD BE

THE AWARD LETTER FROM
SOCIAL SECURITY.

THE OTHER THING THAT YOU MIGHT
BE LOOKING FOR IS YOU MAY HAVE

SOMEBODY TELLING YOU THAT THIS
PERSON IS IN A NURSING HOME

IN AN INSTITUTIONAL SETTING,
HAS MEDICARE OR MEDICAID,

AND THEREFORE THERE SHOULD
BE NO COPAY LEVEL.

AND AGAIN, YOU NEED
TO HAVE INFORMATION.

YOU NEED TO HAVE SOME KIND OF
WRITTEN PRINTED MATERIAL THAT

SHOWS THAT.

ONE THING WOULD BE A
REMITTANCE FROM THE FACILITY

SHOWING THE MEDICAID PAYMENT

FOR A FULL CALENDAR MONTH

FOR THE INDIVIDUAL DURING A
MONTH AFTER JUNE THE PREVIOUS

CALENDAR YEAR.

REMEMBER A PERSON THAT IS IN A
NURSING HOME THAT HAS MEDICARE

OR MEDICAID, THE MEDICAID
HAS TO BE IN EXISTENCE

FOR AT LEAST ONE MONTH.

SO IF THAT PERSON IS JUST
GETTING THE MEDICAID NOW,

THAT COST-SHARING IS NOT
CHANGING UNTIL THAT MONTH

IS OVER, OK?

ALSO, A COPY OF A STATE
DOCUMENT THAT CONFIRMED THE

MEDICAID PAYMENT ON BEHALF OF
THE INDIVIDUAL TO THE FACILITY

FOR A FULL CALENDAR YEAR
AFTER JUNE OF PREVIOUS

CALENDAR YEAR.

OR A SCREEN PRINT FROM THE
STATE'S MEDICAID SYSTEMS

SHOWING THAT THE INDIVIDUAL'S
INSTITUTIONAL STATUS BASED

ON AT LEAST A FULL CALENDAR
MONTH STAY FOR MEDICAID

PAYMENT PURPOSES DURING
A MONTH AFTER JUNE

OF THE PREVIOUS CALENDAR YEAR.

SO THERE IS DEFINITE SPECIFIC
DOCUMENTATION THAT HAS TO BE

RECEIVED THAT YOU NEED TO HAVE
IN YOUR RECORDS TO PROVIDE

THE CORRECT INFORMATION
IN YOUR SYSTEM.

NOW, FOR A PERSON THAT IS NOT
DEEMED BUT HAS GOTTEN THEIR

EXTRA HELP THROUGH SOCIAL SECURITY, THERE IS A SOCIAL

SECURITY AWARD LETTER.

AND THAT SOCIAL SECURITY AWARD LETTER SAYS THAT THIS PERSON

IS NOW ELIGIBLE FOR EXTRA HELP, AND IT SHOULD SAY WHEN.

AND IF THEY ARE GETTING IT FROM SOCIAL SECURITY, IT'S NOT

GOING TO BE A COPAY LEVEL TWO.

IT'S GONNA BE A COPAY LEVEL ONE.

OK?

NOW, PLAN RESPONSIBILITY: THE PLANS MUST ACCEPT AND USE

THE BAE TO UPDATE THEIR OWN SYSTEMS FOR THESE

BENEFICIARIES AS FOLLOWS.

OK, AS SOON AS YOU GET ONE FORM OF BAE, THE PLAN MUST

PROVIDE THE BENEFICIARY ACCESS TO THE COVERED PART D DRUGS

AT THE REDUCED COST-SHARING THAT'S NOT GREATER THAN

THE HIGHEST LEVEL FOR A FULL BENEFIT DUAL ELIGIBLE OR ZERO

IF THE BAE SUBSTANTIATES INSTITUTIONAL STATUS...OK.

THEY MUST UPDATE THEIR SYSTEMS TO REFLECT THE CORRECT

LOW-INCOME SUBSIDY, OVERRIDE THE STANDARD COST-SHARING,

MAINTAIN AN EXCEPTION PROCESS FOR THE BENEFICIARY, AND AS

OF 1/1/09, TAKE THESE ACTIONS WITHIN 48 TO 72 HOURS

OF RECEIPT OF THE BAE DOCUMENTATION.

IN ADDITION, TO KIND OF BACK

THIS WHOLE THING UP, A PLAN,
EACH PLAN, MUST HAVE
APPROPRIATE MEMBER SERVICES

AND PHARMACY HELP DESK
INDIVIDUALS SCRIPTING TO

TRIAGE THESE CASES, AND SHOULD
HAVE PROCEDURES TO ADDRESS

THE URGENT CASES.

BASICALLY, WHAT WE'RE SAYING
IS THAT BAE IS VERY IMPORTANT

TO THE PROGRAM.

THIS WHOLE PROCESS WAS PUT
FORTH BECAUSE PEOPLE WERE

HAVING PROBLEMS GETTING THEIR
DRUGS AT THE RIGHT

COST-SHARING LEVEL.

SO WHAT WE'RE ASKING YOU TO
HAVE ON HAND IS SOMETHING

WITHIN YOUR ORGANIZATION
THAT'S GOING TO WORK TO GET

THIS DONE.

AND WE CONSIDER IT VERY,
VERY IMPORTANT BECAUSE ANYTIME

ONE OF OUR MEMBERS--ONE OF OUR
BENEFICIARIES AND YOUR MEMBER

CANNOT GET THE DRUGS AT THE
RIGHT COST-SHARING LEVEL,

THAT MEANS THEY DON'T HAVE
ACCESS TO THEIR DRUGS,

AND THAT'S THE PRIME PART
OF THIS WHOLE PROGRAM,

THE PRESCRIPTION DRUG
COVERAGE, THAT THEY GET

THE DRUGS THEY NEED.

OK, NOW, ONCE THE PLAN
CORRECTS THE BENEFICIARY'S

COST-SHARING LEVEL, IN THEIR
OWN SYSTEM--WHEN WE TALK

ABOUT THE PLAN CORRECTING,

WE'RE TALKING ABOUT THEM
CORRECTING THEIR OWN SYSTEM,

THEIR OWN PHARMACY SYSTEM.

SO THE PERSON IN THE PHARMACY
IS ABLE TO PROCESS THE CLAIMS

AT THE RIGHT
COST-SHARING LEVEL.

BUT IN ADDITION, THE PLAN HAS
TO GO AND LOOK AND SEE WHETHER

OR NOT CMS' SYSTEM SHOWS
THAT PARTICULAR LEVEL.

IT MAY.

THEY MAY GO IN AND IT MAY
HAVE IT ALREADY.

IT MAY HAVE THAT INFORMATION,
AND IT MAY NOT.

AND IF IT DOESN'T, THEN THE
PLAN SHOULD WAIT 30 TO 60 DAYS

FOR CMS TO--FOR THE DATA TO
AUTO-CORRECT, IN OTHER WORDS,

FOR THE SYSTEM TO RECEIVE
THE INFORMATION AND UPDATE.

NOW, IF THE CMS DATA DOES NOT
AUTO-CORRECT

WITHIN THE 30-TO-60-DAY PERIOD,

THEN THE PLAN
MUST SEND THE INFORMATION

TO A CONTRACTOR, WHICH IS NOW--I
THINK AT ONE POINT WE WERE

TALKING INTEGRIGUARD.

NOW IT'S REED AND ASSOCIATES.

OK?

AND IN THIS SLIDE, IT TELLS
YOU EXACTLY HOW TO DO IT.

IT'S A DISK.
IT'S PASSWORD-PROTECTED.

THERE'S A SIGNED CERTIFICATION
ATTESTING TO THE ACCURACY

OF THE INFORMATION
AND AN E-MAIL WITH

THE SPREADSHEET PASSWORD.

SO THERE IS A PROCESS THAT
HAS TO BE DONE, AND THAT'S

BECAUSE IF IT DOESN'T UPDATE
WITHIN THE 30-60 DAYS, THEN WE

NEED TO PUSH IT FURTHER TO
GET EVERYTHING CLEAR

AND ABOVE BOARD.

>> NOW, IN TERMS OF RETAINING

THE INFORMATION, YOU HAVE
CERTAIN REQUIREMENTS.

THE PLAN MUST RETAIN THE BAE
DOCUMENTATION FOR MANUALLY

UPDATING THE CMS
SYSTEM FOR 10 YEARS.

AND YOU CAN WORK
THROUGH A CONTRACTOR.

YOU CAN DELEGATE SOME KIND OF
AN ARRANGEMENT WITH A TRUSTED

BUSINESS PARTNER FOR THEM
TO DO THIS TO RETAIN THIS

INFORMATION FOR YOU.

OK. NOW, GOING BACK TO THE CTM,
WHICH IS THE COMPLAINT-

TRACKING MODULE, THERE IS
A CATEGORY IN THE CTM WHICH

ACTUALLY REFLECTS WHEN A PLAN
FAILS TO HAVE A BAE PROCESS

IN PLACE OR WILL NOT HONOR
ACCEPTABLE EVIDENCE PROVIDED

BY THE BENEFICIARY OR SOMEONE
ON HIS OR HER BEHALF.

AND CMS LOOKS TO SEE WHAT
THE PLANS--THE PLAN MANAGERS

AND THE PLAN ANALYSTS ARE

LOOKING TO SEE THEIR PLANS,

WHAT KIND OF ACTIVITY IS GOING
ON IN THAT PARTICULAR AREA.

DOES A PLAN HAVE
A LOT OF THESE?

IS THERE AN ISSUE?

WHY ISN'T THAT PLAN
ACCEPTING THE BAE's?

IS IT A PROBLEM BECAUSE THE
PERSON WHO'S GIVING IT TO THEM

IS NOT GIVING THE
CORRECT INFORMATION?

OR IS IT A FACT THAT SOMEONE
LOOKING AT IT, AT THE PLAN,

DOESN'T UNDERSTAND WHAT TO
DO WITH IT WHEN THEY GET IT?

SO THIS IS ONE OF THE ISSUES
THAT THE PLAN MANAGERS

AND ANALYSTS ARE LOOKING
FOR IN TERMS OF COMPLIANCE.

NOW, WHEN THE BENEFICIARY DOES
NOT HAVE THE BAE BUT THEY'VE

CONTACTED YOU TO TELL YOU
THAT, "THERE'S SOMETHING WRONG

AND THIS IS NOT WHAT I SHOULD
BE PAYING FOR MY DRUGS,"

YOU NEED TO HELP THEM OUT.

WHAT DO YOU DO?

WELL, WE'RE GONNA
WORK WITH YOU ON THAT.

AND IF YOU'VE BEEN WORKING
WITH BAE, YOU MAY ALREADY KNOW

THIS, BUT THERE IS A WORKSHEET
THAT YOU COMPLETE, AND YOU

COMPLETE THE CERTAIN COLUMNS,
A THROUGH F.

YOU SEND IT INTO THE REGIONAL
OFFICE, THE APPROPRIATE

REGIONAL OFFICE, AND THEN

WE CONTACT THE STATE AND WE

CONTACT THE APPROPRIATE PARTY,
AND WE GET THE INFORMATION

THAT'S NEEDED TO REFLECT
THIS PERSON'S DEEMED STATUS,

INSTITUTIONAL STATUS, OR
EVEN IF IT'S AN SSA,

THE LOW-INCOME SUBSIDY.

AND WE FILL OUT THE REST OF
THE WORKSHEET, AND THEN WE GET

IT BACK TO YOU.

AND YOU'RE SUPPOSED TO
DESIGNATE, IF YOU ARE SENDING

THE WORKSHEET TO US,
THE IMMEDIATE NEED

AND THE NON-IMMEDIATE NEED.

OK?

SO THIS IS WHAT WE DO:

WE CHECK THE MBD.

WE CALL THE STATE.

IF THE STATE CONFIRMS THE
INFORMATION BUT IT'S NOT

REFLECTED IN WHAT THE STATE
HAS SENT OVER TO US, THEN THEY

SEND IT OVER TO US TO
UPDATE THE RECORDS.

AND THEN WE JUST PUT ALL
THE INFORMATION DOWN

ON THE WORKSHEET, H THROUGH Q,
AND THEN WE SEND IT BACK TO

THE PLAN WITHIN ONE BUSINESS
DAY OF RECEIVING

THE INFORMATION FROM THE STATE
FOR IMMEDIATE NEED CASES.

NOW, THE PLAN THEN MUST NOTIFY
THE BENEFICIARY OF THE RESULTS

OF THE CMS INQUIRY, AND THIS
IS OUTLINED IN THE HPMS.

THERE'S A WHOLE AREA WHERE
THERE ARE CMS DOCUMENTATIONS

OR DOCUMENTS, MEMORANDUMS,

AND THERE ARE SEVERAL IN THERE.

WE WROTE THEM IN HERE
ORIGINALLY, BUT THEN WE

NOTICED THAT THERE WERE SO
MANY UPDATED--ONE CAME OUT

MAY 4, 2009; AND THEN THERE WAS
ANOTHER ONE, AUGUST...

AUGUST 2008,
THEN IT WAS MAY 2009.

SO INSTEAD OF PUTTING ANY
DATED MEMOS IN HERE, IF YOU GO

INTO HPMS, YOU CAN GET
THE LATEST INFORMATION.

AND THAT IS ALWAYS BEING

UPDATED, SO YOU REALLY SHOULD

STAY ON TOP OF IT.

AND AS SOON AS THE PLAN
RECEIVES CONFIRMATION FROM CMS

THAT THE BENEFICIARY IS
SUBSIDY ELIGIBLE, IT MUST

PROVIDE THE BENEFICIARY ACCESS
TO THE COVERED PART D DRUGS

AT THE REDUCED COST-SHARING
LEVEL, OR ZERO IF THEY'RE

INSTITUTIONALIZED, BECAUSE
THAT'S WHAT THE BAE POLICY

IS ALL ABOUT.

THE END TAIL OF THIS IS THAT
THE BENI GETS THEIR DRUGS

AND THEY GET THEM AT THE
RIGHT COST-SHARING LEVEL,

BECAUSE SOMETIMES THEY CAN'T
GET THEM IF THEY CAN'T

AFFORD THEM.

OK, NOW, THIS IS IMPORTANT,
ALSO, THAT ONCE THE PLAN

UPDATES THEIR INTERNAL SYSTEMS
AND THE BENEFICIARY GETS HIS

OR HER DRUGS AT THE CORRECT
COST-SHARING LEVEL, THE PLAN

CAN CLOSE OUT THE CTM CASE.

EVEN IF THEY'VE NOTIFIED--
THEIR NOTIFYING

REED AND ASSOCIATES TO UPDATE
THE SYSTEMS, THE CMS SYSTEMS--

IF THE BENI HAS GOTTEN THE
DRUGS, YOUR INTERNAL SYSTEMS

ARE CORRECTED, YOU CAN CLOSE
OUT THAT PARTICULAR CTM CASE

THAT YOU HAVE, BECAUSE
REMEMBER, THERE COULD BE

A TIME SPAN THERE WHEN REED
AND ASSOCIATES IS GONNA MAKE

CORRECTIONS AND SO FORTH,

AND THEN YOU'RE GONNA BE
PENALIZED FOR TIME FRAME.

OK? SO THAT'S IMPORTANT.

THERE'S ONE OTHER THING WE
WANTED TO MENTION HERE SO YOU

HAVE AN IDEA IN
TERMS OF TERMINOLOGY.

THE LIMITED INCOME NET--LI NET--

THIS IS A NEW PROGRAM THAT
STARTED IN 2010.

IT HANDLES THE RETROACTIVE
AUTO-ENROLLMENT PROCESS

FOR THE FULL DUALS
AND THE SSI ONLY.

NOW IN NEW YORK AND NEW
JERSEY, IF YOU'RE FULL DUAL--

IF YOU HAVE SSI, YOU'RE
LIKE A FULL DUAL.

BUT IN OTHER STATES, SSI

MAY BE A SEPARATE CATEGORY.

THAT'S WHY WE BROKE IT OUT
LIKE THIS, BECAUSE WE KNOW

WE'RE A BI-REGIONAL CONFERENCE.

SO THIS LI NET PROGRAM HANDLES
THESE RETROACTIVE

AUTO-ENROLLMENT INDIVIDUALS,
HANDLES A POINT-OF-SALE

FACILITATED ENROLLMENT

FOR ALL LOW-INCOME SUBSIDY
ELIGIBLE BENEFICIARIES.

IT'S ADMINISTERED BY HUMANA.

NOW, WE HAD THE POINT
OF SALE BEFORE.

WE HAD OTHER PROCESSES.

BUT THIS IS A UNIFORM--ALL
HANDLED BY HUMANA.

THEY HAVE A SPECIAL PLAN.

THE PLAN IS VERY EASY TO
WORK IN TERMS OF THE PROCESS

BECAUSE IT'S AN
OPEN FORMULARY.

ALL RIGHT.

THE LI NET IS USED WHEN
THE BENEFICIARY HAS NO

PART D PLAN.

OK? WHEN A PERSON IS IN A PLAN
AND THE COST-SHARING LEVEL IS

INCORRECT, THEN WE'RE USING
BAE IF WE HAVE TO MAKE

A CORRECTION.

SO LI NET ONLY COMES INTO PLAY
WHEN THEY HAVE NO PART D PLAN,

AND THAT'S WHY YOU'RE PROBABLY
NEVER GONNA BE INVOLVED IN IT,

BECAUSE ONCE THEY HAVE
A PART D PLAN,

THEY'RE NOT USING--

THE LI NET PROCESS IS NOT
GONNA BE--YOU KNOW, YOU'RE NOT
WORKING WITH IT.

NOW, IN TERMS OF BEING
ELIGIBLE FOR THE LI NET, HOW DO

I PROVE THAT I AM ELIGIBLE TO
HAVE A POINT OF SALE OR SOME

KIND OF RETROACTIVE
AUTO-ENROLLMENT?

AND THAT WOULD BE YOU HAVE
YOUR MEDICARE AND YOUR

MEDICAID CARD, YOU HAVE
AN SSA AWARD LETTER.

THAT'S THE TYPE OF EVIDENCE
THAT WE'RE LOOKING FOR.

BUT AGAIN, AS A PLAN YOU'RE
NOT GONNA SEE THIS, BECAUSE IF

YOU'RE A PLAN AND YOU'RE
SEEING THIS, IT'S NOT LI NET.

IT'S BAE.

>> DOES ANYBODY HAVE ANY
QUESTIONS ABOUT THIS

OR ANYTHING ELSE?

I SEE A HAND.

WAIT, WAIT. OK.
YOU SOUND LOUD.

[LAUGHTER]

>> THE LI NET--NOW, ARE THESE
PEOPLE, WHEN THEY DO JOIN

A PART D PLAN, ARE THEY
GONNA BE PENALIZED?

>> NO. WELL, THEY'RE NOT GONNA
BE PENALIZED, NO.

THE OTHER THING IS,
WITH LI NET, THEY GO INTO

THE HUMANA PLAN, AND THEN CMS
WILL ASSIGN THEM TO A PLAN THAT

IS ONE OF THE BENCHMARK PLANS.

GO AHEAD. I'M SORRY.

OH, NO. WELL, THEY WOULDN'T.
RIGHT.

NO, THEY WOULDN'T BE PENALIZED
BECAUSE THEY'RE DUAL-ELIGIBLE,

ANYHOW, UNLESS I'M NOT--WHY
DID YOU THINK THEY WOULD

BE PENALIZED?

>> WELL,
BECAUSE YOU SAID THEY HAD NO

PART D PLAN, BUT I MUST HAVE
FALLEN ASLEEP FOR A SECOND.

>> OH, NO, NO, NO.

>> ...THEN PUT THEM
IN LI NET...

>> WELL, FOX WAS

A LITTLE DIFFERENT BECAUSE
FOX--THESE PEOPLE--ANYBODY

THAT WAS IN FOX WAS PUT INTO
THE LI NET --THANK YOU--

THE LI NET, AND NOT ALL THE
FOX BENEFICIARIES WERE

LOW-INCOME SUBSIDY.

BUT, YES, THEY ALL WENT IN
THERE, AND THEY'RE GOING TO BE

REASSIGNED TO PLANS AS OF 6/1.

MM-HMM.

DOES ANYBODY ELSE HAVE
ANY OTHER QUESTIONS?

I THINK WHAT'S VERY IMPORTANT--
I JUST WANT TO MENTION

WITH THE BEST AVAILABLE
EVIDENCE, I THINK THAT IT'S

VERY IMPORTANT TO UNDERSTAND
THAT THERE IS A PROCESS AND IF

THE ONLY ISSUES THAT YOU HAVE
ARE THAT YOU'RE NOT SURE

WHAT'S ACCEPTABLE OR NOT,
THAT'S SOMETHING YOU MAY WANT

TO DISCUSS WITH YOUR
PLAN MANAGERS OR YOUR

PLAN ANALYSTS.

AND I THINK THAT'S IMPORTANT,
THAT YOU HAVE THE INFORMATION

FOR WHOEVER WOULD BE DEALING
WITH THESE SITUATIONS,

THAT THEY'RE ABLE TO RECOGNIZE
IT SO THAT EITHER

THE BENEFICIARY HAS INFORMATION
OR YOU GET INFORMATION.

NOW, WHEN YOU GET A CTM
REQUEST IN, WE USUALLY SAY

ON THE CTM, IN THIS SCENARIO,
WE'LL SAY, "WE HAVE AVAILABLE

THE STATE EVIDENCE,"
OR THE COUNTY EVIDENCE.

"PLEASE LET US KNOW,
AND WE'LL FAX IT TO YOU."

OK? SO SOMEBODY HAS
THE INFORMATION.

AND I KNOW ONE OF THE PROBLEMS
THAT I'VE COME ACROSS IS THAT

SOMETIMES THE PLAN'S STAFF
DOESN'T KNOW HOW TO READ

THE EVIDENCE THAT THEY MAY GET
FROM US OR THEY MAY GET FROM

A BENEFICIARY OR
FROM A NURSING HOME.

AND IF THAT'S THE CASE,
WHAT YOU NEED TO DO IS YOU

NEED TO LET YOUR PLAN
MANAGERS, PLAN ANALYSTS,

OR WHOEVER WITHIN YOUR
ORGANIZATION TALKS TO THOSE

PEOPLE SO THAT THEY CAN GET
INFORMATION, BECAUSE YOU CAN

DEFINITELY MAKE A CHEAT SHEET,
SO TO SPEAK, SO THAT YOU CAN

UTILIZE THAT.

WHAT WE DON'T WANT IS WE DON'T
WANT THE BENEFICIARY NOT TO

GET THEIR DRUGS AND TO
HAVE WAIT AROUND UNTIL IT'S

FINALLY RESOLVED.

BOTTOM LINE IS THE BENEFICIARY
NEEDS TO GET THEIR DRUGS,

AND THAT'S WHAT'S
THE IMPORTANT THING.

AND IN TERMS OF ANY KIND OF
CTM CASE, AND THEY GO BACK

AND FORTH, BACK AND FORTH,
THAT BENEFICIARY IS STILL

HANGING AROUND THERE.

SO WHAT WE SAY IS YOU HAVE TO
FIX YOUR SYSTEM TO ALLOW THEM

ACCESS, AND THEN YOU CAN WORRY
ABOUT WHAT ELSE IS GOING ON IF

CMS' SYSTEM IS INCORRECT OR
SOMETHING ELSE IS GOING ON,

BUT YOU HAVE TO CORRECT YOUR
INTERNAL SYSTEM,

LET THE BENEFICIARY GET ACCESS
TO THEIR MEDICATION, AND THEN WE

CAN ALL WORK TOGETHER AND
BE A HAPPY FAMILY.

OK, DOES ANYBODY HAVE
ANY OTHER QUESTIONS?

YES.

>> YEAH. IF YOU HAVE OR PLAN TO
RECEIVE BAE--LET'S SAY IT'S

ABOUT A YEAR AND A HALF,
MAYBE TWO YEARS AGO--

AND THE MEMBER THEN CONTACTS THE
PLAN INDICATING THAT THEY

BELIEVE THAT THEIR LIS LEVEL
SHOULD BE DIFFERENT,

BUT THE MEMBER'S

STATUS HAS NOT BEEN UPDATED IN
A YEAR AND A HALF, TWO YEARS

OR SO BY SSA, WHAT DOES--

>> SSA OR THE STATE?

>> THE STATE.

>> OK. NOW, IT'S VERY POSSIBLE
THAT AN INDIVIDUAL'S STATUS MAY

HAVE CHANGED.

PEOPLE CAN GO FROM COPAY
LEVEL ONE TO COPAY LEVEL TWO.

THEY CAN GO FROM ONE OR TWO TO
ZERO IF THEY'RE IN A NURSING

HOME, SO THAT IT'S VERY
POSSIBLE THIS PERSON IS AWARE

OF SOME CHANGE IN THEIR
STATUS, SO WHAT YOU NEED TO

ASK THEM FOR IS, WHAT EVIDENCE
DO THEY HAVE TO REFLECT

THE CHANGE IN THEIR
COST-SHARING LEVEL?

AGAIN, GOING BACK
TO THE BAE--GO AHEAD.

>> ...SUBMIT THE REQUEST TO
THE PART D COMPLAINT BOX,

AND CMS COULD CONFIRM WHETHER
THE BENEFICIARY'S COPAY LEVEL

DID CHANGE.

>> NOW, IS THAT DONE IN EVERY
REGIONAL OFFICE?

ALL THE OTHER
REGIONS OR JUST US?

>> IT'S A BAE PROCESS.
THEY NEED ASSISTANCE FROM CMS.

>> GO AHEAD.
SHE'LL REPEAT IT.

>> YOU KNOW, YOU COULD SEND
THE BENI'S INFORMATION TO

CMS, AND CMS COULD CONTACT THE
STATE TO VERIFY HIS CORRECT

LEVEL, COST-SHARING LEVEL.

SO THAT'S THE BEST ROUTE TO
GO, BECAUSE IF--YOU KNOW,

I DON'T THINK THEY WOULD
HAVE EVIDENCE TO SHOW.

THE BENEFICIARY WON'T HAVE
EVIDENCE TO SHOW WHAT COST

LEVEL HE'S AT, SO THE BEST
WAY FOR YOU TO DO IT IS SUBMIT

IT TO CMS,
AND CMS WILL HELP YOU OUT.

>> THE REASON I'M ASKING IS
BECAUSE WE RECEIVED A CTM,

AND THE MEMBER WAS COMPLAINING
ABOUT THEIR COST-SHARING LEVEL,

SO CMS DIRECTED
US TO CONTACT SSA

BECAUSE THE MEMBER'S
LEVEL HAS NOT BEEN CHANGED

IN SEVERAL YEARS.

>> THAT WAS A LEVEL ONE,
AND THAT WAS AN AWARD LETTER.

>> BECAUSE THE AWARD LETTER
WAS SEVERAL YEARS OLD AND IT

HAD NEVER BEEN UPDATED.

SO WHEN WE CONTACTED SSA,

SSA SAID THAT YOU SHOULD
CONTACT CMS.

AND THEN WHEN WE CONTACTED
CMS, CMS SAID WE SHOULD

CONTACT THE SSA.

SO WE'VE BEEN GOING AROUND
IN THIS LITTLE CIRCLE.

>> WHAT STATE ARE

WE TALKING ABOUT?

>> I'M SORRY?

>> WHAT? I'M SORRY, REGION.

WHERE ARE YOU, REGION
ONE OR REGION TWO?

>> WELL, OUR LEAD
REGION IS REGION 9.

>> OH, THAT'S NICE. OK.
THE REASON...

[LAUGHTER]

>> SORRY ABOUT THAT.

THE REASON WHY I ASKED YOU
IS IT JUST MAY BE A MATTER

OF JUST GETTING THE
MESSAGE STRAIGHT.

BASICALLY, WHAT LINDA JUST
MENTIONED BEFORE ABOUT HER

COMPLAINT BOX--OR NOT HERS,
BUT THE COMPLAINT BOX

IN THE REGIONAL OFFICE--THAT
TO ME IS THE MOST DIRECT WAY

OF DOING IT, RATHER THAN
BOUNCING BACK AND FORTH LIKE

A MARBLE OR A BALL,
BUT--GO AHEAD.

>> THERE SEEMS TO BE AN ISSUE
THERE, BECAUSE YOU'RE SAYING

SSA AWARD LETTER,
BUT MEANWHILE YOU'RE SAYING

IT'S FROM THE STATE, SO IT'S
REALLY TWO DIFFERENT AGENCIES

THAT YOU HAVE TO, LIKE,
GET STRAIGHT, YEAH.

>> OK. JUST BACKTRACKING ONE
STEP BACK, WE KNOW THAT

PEOPLE ARE DEEMED.

THOSE ARE THE PEOPLE THAT,
BASED ON THEIR FINANCIAL NEED,

THEY'RE ELIGIBLE FOR THE
MEDICAID, THE MEDICARE

SAVINGS PROGRAMS.

THOSE ARE THE
DEEMED INDIVIDUALS.

WE KNOW THE INDIVIDUALS THAT
DON'T MAKE THOSE INCOMES

POSSIBLY ARE ELIGIBLE
THROUGH SOCIAL SECURITY.

THEY HAVE EXTRA HELP, ALSO.
YOU FILL AN APPLICATION OUT.

SO IT DEPENDS UPON WHERE THIS
PERSON IS GETTING THEIR EXTRA

HELP FROM, OK?

NOW, IT'S POSSIBLE THAT THEY
WERE GETTING IT FROM SOCIAL

SECURITY AND THEY LOST THEIR
HOUSE AND THEY HAD A TORNADO

AND NOW THEY'RE
GETTING STATE AID.

SO IT'S POSSIBLE,
BUT--GO AHEAD.

>> YEAH, BUT I THINK EACH
REGIONAL OFFICE HAS A SSA

CONTACT TO VERIFY
THEIR EXTRA HELP, SO...

>> YOU STILL NEED TO
GO TO THE REGIONAL OFFICE.

>> HE SAID CMS SENT HIM TO...

>> WELL, WE DON'T KNOW
WHO CMS IS.

>> YEAH, WE DON'T...OF COURSE,
IT'S REGION TWO.

[LAUGHTER]

>> YOU KNOW WHAT
WE'RE TRYING TO SAY.

I MEAN,
WE CAN ONLY TELL YOU WHAT

WE'RE DOING IN OUR REGIONAL

OFFICE, AND WE ASSUME

EVERYBODY ELSE IS DOING THE
SAME, BUT WE DON'T KNOW WHO

THE CMS IS.

I MEAN...SO YOU NEED TO GO
BACK TO YOUR REGIONAL OFFICE,

THEN, AND TALK TO THEM,
OR TALK TO YOUR PLAN MANAGER

OR YOUR PLAN ANALYST.

THEY DON'T BITE, AND
THEY'RE USUALLY VERY NICE.

>> OUR PART D ACCOUNT MANAGER
IS INVOLVED IN THIS, SO...

>> OK. GOOD.

WE FIND WHEN WE HAVE
ISSUES THAT DEAL WITH SOCIAL

SECURITY, IT'S A LITTLE
HARDER SOMETIMES TO GET

THE INFORMATION BECAUSE WHEN
WE GET THE AWARD LETTERS,

SOMETIMES WE'RE FUSSING WITH
THEM IN TERMS OF LEVELS.

BUT IF YOU'RE GETTING YOUR
EXTRA HELP THROUGH SOCIAL

SECURITY, IT'S USUALLY
A LEVEL ONE.

IT'S NOT A LEVEL TWO,
OK, BECAUSE LEVEL TWOS ARE

USUALLY THE STATE.

AND THEN THE ZEROES ARE WHEN
THEY'RE INSTITUTIONALIZED

AND THE NURSING HOME HAS
RECEIVED THE MEDICAID PAYMENT

FOR A MONTH.

SO THAT'S USUALLY
THE WAY IT WORKS.

BUT AGAIN, YOUR BEST SOURCE OF
INFORMATION IS ALWAYS GOING TO

BE YOUR ACCOUNT MANAGER,
BUT THEN YOUR REGIONAL OFFICE,

WHICHEVER ONE YOUR LEAD
REGIONAL OFFICE IS. OK?

>> I HAVE ONE
ADDITIONAL QUICK QUESTION.

IT'S NOT SPECIFIC TO THIS
PROCESS, BUT IT'S ACTUALLY

THE BAE MONITORING PROCESS.

AND IT ACTUALLY HAS TO DO
WITH LIS AND THE BAE

MONITORING PROCESS.

THE LIS MATCH RATE
PERCENTAGE FOR A PLAN TO BE

IN COMPLIANCE IS 95%.

>> RIGHT.

>> LET'S SAY YOUR
PLAN COMES IN AT 97%.

YOU MEET COMPLIANCE,
BUT THERE'S STILL THAT 3% THAT

YOU MAY NOT BE
MATCHING WITH CMS.

SHOULD A PLAN BE REACHING
OUT TO THOSE BENEFICIARIES

PROACTIVELY TO ATTEMPT TO FIND
OUT WHY THERE IS THAT--

WHY YOU'RE NOT MATCHING--WHY
ARE PLANNED LIS LEVELS NOT

MATCHING WITH MARKS?

>> I MEAN, I WOULD TALK TO MY
PLAN MANAGER OR PLAN ANALYST.

FROM MY PERSPECTIVE,
YES, I WOULD.

I MEAN,
I DON'T KNOW WHAT EVERYBODY

ELSE--I MEAN, I WOULD THINK
THAT I WOULD ALWAYS STRIVE

FOR THE 100% RATHER THAN 97%,

BUT IN TERMS OF COMPLIANCE,

YOU ONLY NEED THE
97--WHATEVER.

THANK YOU, 95. I HAVE 97.

PROBABLY SOMEONE GOT
A MARK OF 97.

BUT I WOULD ALWAYS STRIVE FOR
THE 100 BECAUSE YOU'RE GETTING

A LITTLE BIT OF LEEWAY.

BUT AGAIN, I WOULD TALK TO MY
PLAN MANAGER AND SEE WHAT THE

EXPECTATION OF THAT REGIONAL
OFFICE, THAT PARTICULAR

REGIONAL OFFICE IS,
AND HOW THEY MONITOR.

I MEAN, DOES ANYBODY--
HOW DOES--I'M JUST CURIOUS.

IN OTHER PLANS,
WHAT DO YOU DO?

YOU HAVE A SIMILAR SITUATION,
WHERE IT'S 95%.

WHAT DO YOU DO WITH THAT OTHER
PERCENTAGE THAT--YOU KNOW,

IF YOU MAKE THE LEVEL AND
THERE ARE PEOPLE THAT ARE

NOT--HAVEN'T BEEN HELPED,
I GUESS, WHAT DO YOU DO?

DO YOU GO OUT
AFTER THEM OR NOT?

SOMEBODY SAY SOMETHING.

NOBODY?

YOU DON'T KNOW.
YOU'RE NOT SURE.

YEAH.

>> IT'S NOT PART OF--I
DON'T BELIEVE THAT IT'S PART

OF THE CMS POLICY THAT A PLAN
HAS TO GO OUT AND CONTACT

THAT BENEFICIARY.

>> NO. IT'S NOT.
NO, IT'S NOT.

>> AND I SEE WHERE HE'S
COMING FROM, NOT JUST ON THIS

SUBJECT, BUT WHEN YOU TALK
ABOUT THE BENEFICIARY, I THINK

THERE'S A DISCREPANCY
SOMEWHERE AND IT ENDS UP GOING

TO SOCIAL SECURITY OR TO THE
STATE, BUT THEN GETTING THEIR

MEDICATION, YOUR CHANCES OF
GETTING THROUGH TO THAT MEMBER

IS ALMOST ZERO BECAUSE THEY'RE
GETTING WHAT THEY NEED.

SO GETTING THEM TO CORRECT
THAT SITUATION AND GETTING

THEM TO GO TO THOSE OFFICES
WHERE IT'S ALMOST--THEY ALMOST

DON'T GET ANY
RESPONSE, EITHER.

YOU KNOW, THEY--YOU'RE
PROBABLY NOT GETTING

POSITIVE RESPONSE.

>> WE'RE VERY INVOLVED WITH
THE BENEFICIARY SIDE OF IT.

SO WE'RE ALWAYS GETTING THE
CALLS FROM THE BENEFICIARIES,

AND WE'RE ALWAYS HELPING
THEM GET RESOLVED.

SO IT'S POSSIBLE YOU DON'T SEE
IT, BUT THEY MAY EVENTUALLY

COME TO US, AND THEN
WE'RE WORKING A CASE.

AND WE'RE CONTACTING EVERYBODY
UNDER THE SUN TO HELP

THE BENEFICIARY OUT.

THAT'S WHAT THE CUSTOMER
RELATIONS BRANCH DOES.

SO IT MAY BE--GO AHEAD.
YOU WERE GONNA SAY SOMETHING?

SO IT MAY BE THAT FROM THE
PLAN'S PERSPECTIVE, YOU'VE

FULFILLED YOUR REQUIREMENT,
BUT THAT BENEFICIARY AT SOME

POINT IS GOING TO ASK FOR
ADDITIONAL HELP, WHETHER THEY

GO INTO THE SHIP OR THEY CALL
THE REGIONAL OFFICE OR THEY

CALL 1-800-MEDICARE.

SO I THINK THAT YOUR JOB IS TO
CORRECT YOUR SYSTEMS AND GIVE

THAT INDIVIDUAL ACCESS TO THE
APPROPRIATE DRUGS THAT THEY

NEED AND FULFILL WHATEVER
REQUIREMENTS THAT YOU NEED.

AND IF YOU WANT TO GO ONE
STEP BEYOND, THAT'S YOUR

PLAN'S DECISION.

BUT THE BENEFICIARY IS GONNA
GET HELP SOMEWHERE IF THEY

ASK FOR IT.

DOES ANYBODY ELSE HAVE
ANY OTHER QUESTIONS?

I JUST WANTED--I WAS GOING
BACK IN THE--WHILE I WAS

DOING THIS.

THERE WAS SOMETHING IN HERE
THAT I DON'T REMEMBER IF I

MENTIONED, AND I
WANTED TO MENTION IT.

BUT I'LL NEVER FIND IT IN TIME,
ANYHOW, SO IT'S PROBABLY--

OH, I KNOW WHAT I
WANTED TO TELL YOU.

WHEN YOU SEND THE WORKSHEET--

THAT'S WHAT I WANTED

TO MENTION.

WHEN YOU SEND THE WORKSHEET,
THAT WORKSHEET SHOULD BE SENT

TO THE CMS REGIONAL OFFICE
WHERE THE PERSON LIVES,

NOT THE LEAD REGION.

OK? I WASN'T SURE IF I
HAD SAID THAT.

IT GOES TO WHERE THE PERSON
RESIDES, NOT THE LEAD REGION

FOR THE PLAN, OK?

OK, SO NO OTHER QUESTIONS?

DO YOU HAVE ANY
QUESTIONS ABOUT ANYTHING?

[LAUGHTER]

>> OK. WELL, IT'S 5:00,
SO WE DID GOOD.

HAVE A VERY NICE
EVENING, EVERYBODY.