



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN SPRING CONFERENCE

Sheraton Baltimore City Hotel, April 20-21, 2010

Verbatim Transcript

CY 2011 Plan Benefit Package (PBP) Software Training Advanced Users

Part 1

THANK YOU GUYS
FOR COMING.

IT'S THE PBP 2011
ADVANCED TRAINING.

JUST TO MAKE SURE YOU GUYS
ARE ALL AT THE RIGHT PLACE.

I'M SARA SILVER, IF I
HAVEN'T MET YOU BEFORE,

BUT THERE ARE A LOT OF
FAMILIAR FACES HERE.

SO WELCOME.

AND WELCOME BACK
TO THOSE OF YOU WHO

WERE ALSO HERE DURING
OUR BEGINNING SESSION.

LET'S SEE.
A COUPLE OF THINGS

I JUST WANTED
TO GO OVER.

TO START WITH, KIND OF
THE FORMAT THAT WE'RE

GOING TO DO HERE
IS JUST GO OVER

THE LIST OF CHANGES
FOR 2011.

SO THE ACTUAL
PRESENTATION PORTION

IS MAYBE ABOUT
30 MINUTES
TO 45 MINUTES. WHAT WE
REALLY WANTED TO DO IS

GIVE YOU GUYS A LOT OF
TIME AND OPPORTUNITY

TO ASK THE TYPES OF
QUESTIONS THAT YOU HAVE

ON THE PBP, ESPECIALLY
RELATED, I GUESS,

TO THE PART C
AND PART D POLICY.

WE HAVE A LOT OF
PEOPLE HERE

FROM THE PART C
AND PART D TEAMS.

HAPPY TO, YOU KNOW,
TAKE YOUR QUESTIONS.

AND WHEN WE DO
THE QUESTION PORTION,

I ASK THAT YOU ALL
GO UP TO THE MICROPHONES

ON BOTH SIDES
OF THE ROOM.

AND IF YOU COULD JUST
ASK ONE QUESTION

AT A TIME AND THEN GET
BACK IN LINE,

SO EVERYONE HAS A FAIR
OPPORTUNITY TO ASK

THEIR QUESTION BECAUSE
SOME PEOPLE MAY HAVE

MORE QUESTIONS
THAN OTHERS.

I JUST WANT TO MAKE SURE
EVERYTHING'S FAIR

RELATED

TO THE QUESTIONS.

LET'S SEE. WHAT ELSE DID
I WANT TO GO OVER?

AT THE END OF
THE SLIDES, THERE'S ALSO

A LIST OF POINT
OF CONTACTS.

THE TECHNICAL CONTACTS
ARE STILL ACCURATE.

WE PUT THOSE TOGETHER,
I GUESS, A LITTLE WHILE

AGO, BUT THE CONTACTS

THAT WERE ON THE
PRESENTATION YESTERDAY

DURING THE PART C
AND PART D BENEFITS

SLIDES, THOSE WERE
THE CONTACTS THAT YOU

SHOULD BE USING.
I THINK THEY ALSO HAVE

SOME GENERAL MAILBOXES
THAT YOU SHOULD BE

SENDING
YOUR QUESTIONS TO

FOR THIS UPCOMING
BID YEAR.

AND I THINK THAT'S IT.
I'M ALSO GONNA INTRODUCE

WHO'S PRESENTING.

AND WE'LL INTRODUCE AS
WE GET QUESTIONS WHO

FROM THE PART C AND
PART D TEAMS ARE HERE

AND ANSWERING YOUR
QUESTIONS.

SO I ALREADY
INTRODUCED MYSELF,

BUT I ALSO HAVE ON
THE STAGE

TED BLOSS
FROM FU ASSOCIATES

AND TERI DEUTSCH

FROM THE GALILEO
HEALTH PARTNERS.

AND THEY ARE GOING
TO GO OVER

THE LIST OF CHANGES

AND THEN WE'RE GOING
TO OPEN IT UP

FOR YOUR QUESTIONS.

AND AT THIS TIME, I'LL
TURN IT OVER TO TED.

HI. EVERYBODY.

SO HERE IS THE AGENDA THAT
SARA JUST WENT OVER.

AND LET'S GO AHEAD AND GET

INTO THE MEAT
OF THE PBP HERE.

WE'RE GONNA START WITH
SECTION "A"

THE FIRST ITEM IS SOMETHING
THAT YOU MAY NOTICE.

IT'S ENTIRELY A DISPLAY
ISSUE.

IT DOESN'T ACTUALLY AFFECT
ANY OF YOUR DATA ENTRY,

BUT ANY READ-ONLY ITEMS
ARE NOW GONNA DISPLAY

AS TEXT BOXES.

THE ONLY REASON WE DID
THIS WAS JUST TO MAKE

THE SOFTWARE MORE
508 COMPLIANT.

IF ANYONE IS USING
A SCREEN READER,

IT WILL NOW READ THEM
PROPERLY FOR YOU.

ON A-1, THE SERVICE AREAS
ARE NOW GONNA DISPLAY

IN ALPHABETICAL ORDER
BY STATE AND THEN BY COUNTY.

AND THEY'LL BE ALPHABETICAL
WITHIN EACH STATE AS WELL.

AND ON A-2, SPECIAL NEEDS,
INSTITUTIONAL TYPES

HAVE BEEN UPDATED

TO INSTITUTIONAL,
INSTITUTIONAL EQUIVALENT

LIVING IN THE COMMUNITY

AND INSTITUTIONAL AND
INSTITUTIONAL EQUIVALENT.

THIS SHOULD MATCH WHAT YOU
SEE ON HPMS

AND ANYWHERE ELSE THAT THIS
MAY BE DOCUMENTED.

ON SCREEN A-3, WE'VE ADDED
THE PHARMACY WEB ADDRESS.

YOU POPULATE THIS IN HPMS

IN THE CONTRACT
MANAGEMENT MODULE.

WE'RE JUST PULLING IT DOWN.
IT'S DISPLAY ONLY.

IT'S NOT AN ACTIVE VARIABLE.
THAT'S IT FOR SECTION "A."

SECTION "B." WE'VE ADDED
AN EDIT RULE TO THE SOFTWARE

PREVENTING YOU FROM ENTERING

ANYTHING ABOVE 50%
COINSURANCE FOR

ANY IN-NETWORK,
MEDICARE-COVERED SERVICE

CATEGORY. SO IF YOU TRY TO
GO ABOVE THAT, YOU'RE GONNA

GET A WARNING MESSAGE
FROM THE SOFTWARE.

FOR ESRD 1 PLANS, ALL
AUTHORIZATION AND

REFERRAL QUESTIONS HAVE BEEN
DISABLED, BECAUSE YOU'RE

NOT REQUIRED TO PROVIDE
THAT INFORMATION.

THIS IS A BIG CHANGE.

SEPARATE OFFICE VISIT
COST SHARE.

LAST YEAR, YOU
MAY REMEMBER YOU HAD TO

ENTER THIS AS PART OF
YOUR PCP COST-SHARING.

THIS YEAR
WE'VE BROKEN IT OUT

FOR EACH SERVICE CATEGORY.

AND IT'S AVAILABLE FOR
COINSURANCE AND CO-PAYMENT,

AND IT'S A MIN/MAX. SO YOU
CAN EITHER, YOU KNOW, DO

A RANGE OR JUST ONE
TO COST-SHARE AT EACH

SERVICE CATEGORY LEVEL.

IN B-13c, WE HAVE CHANGED

JUST THE WORDING

OF THE OVER-THE-COUNTER
QUESTION TO MATCH

THE ACTUAL LIST THAT CMS--

OTC LIST VERSUS
THE FSA FED'S OTC LIST.

B-13f. THIS IS A NEW
SECTION OF THE PBP.

IT'S OTHER 2. IT MIRRORS
B-13e, WHICH WAS JUST

"OTHER" LAST YEAR.

I GUESS JUST ONE OTHER WAS
NOT ENOUGH, SO WE'VE ADDED

A SECOND ONE THAT MIRRORS.
AND IT'S EXACTLY THE SAME

AS "OTHER 1," 13e.

IN COMPREHENSIVE DENTAL,
WE HAVE CHANGED

EMERGENCY SERVICES
TO A MORE GENERIC

NON-ROUTINE SERVICES OPTION.

THAT'S IT FOR "B."

SECTION "C." WE'VE
REMOVED THE COST-SHARE

REDUCTION QUESTIONS. ALL OF
THOSE SCREENS HAVE BEEN

REMOVED FROM
THE SOFTWARE, AS HAVE

FOREIGN VISITOR/TRAVEL
BENEFIT SCREENS.

THE U.S. VISITOR/TRAVEL
BENEFIT SCREENS

ARE STILL THERE.

WE HAVE INCORPORATED
13f, "OTHER 2"

INTO ALL OF THE PICKLISTS
IN SECTION "C."

AND, OF COURSE, FINALLY
WE'VE, OF COURSE, UPDATED

13e TO THE "OTHER 1." AND
SIMILAR TO WHAT WE DID

IN-NETWORK, WE'VE GOT

AN EDIT RULE
FOR 50% COINSURANCE

FOR OUT-OF-NETWORK MEDICARE
COVERED SERVICE CATEGORIES

AS WELL.

FOR PPOs, WE HAVE ADDED
A VALIDATION RULE

FOR THOSE CATEGORIES
THERE TO MAKE--

ONLY THE IN-NETWORK
BENEFIT IS MANDATORY.

ANY OF THOSE CATEGORIES ARE
NOT REQUIRED TO OFFER

OUT-OF-NETWORK IF
THE IN-NETWORK BENEFIT IS

NOT OFFERED OR IF IT'S AN
OPTIONAL IN-NETWORK BENEFIT.

FOR THE NEXT ONE, WE JUST
ADDED AN ERROR MESSAGE

TO LET YOU KNOW IF YOU'VE
NOT INCLUDED SOMETHING

IN A GROUP TO MAKE SURE
THAT YOU INCLUDE

ALL THOSE SERVICE CATEGORIES
IN A GROUP WHEN YOU GO BACK,

AND INCLUDE IT IN ONE,

IF YOU GO THROUGH FILLING
OUT ALL YOUR GROUPS

IN SECTION "C" AND YOU
NEGLECTED TO INCLUDE

A SERVICE CATEGORY.

IN SECTION "D," MUCH LIKE
WE DID IN SECTION "C,"

WE HAVE ADDED 13f

TO ALL THE PICKLISTS.

AND FOR OP SUPPS, WE'VE
ADDED A LABEL ON THE SCREEN

TO SHOW EXAMPLES OF

WHAT CANNOT BE AN OPTIONAL
SUPPLEMENTAL BENEFIT.

AND WE'VE ALSO ADDED
A NOTES FIELD

ON THE OPTIONAL
SUPPLEMENTAL LABEL

AND PREMIUM SCREEN.

AND IN CASE YOU USED "OTHER,
DESCRIBE" LAST YEAR--

SOME PEOPLE RAN INTO THIS--

THE NOTES FIELD WAS ACTUALLY
A COUPLE OF SCREENS BEFORE,

WAS THE ONE THAT WE WERE
LOOKING FOR YOU TO USE,

AND THAT WAS A LITTLE BIT
COUNTERINTUITIVE

AS FAR AS THE DATA ENTRY
WENT. SO WE ADDED IT THERE

ON THE LABEL AND PREMIUM
SCREEN,

SO IT'S AFTER YOU'VE DONE
YOUR DATA ENTRY.

SECTION Rx. A LOT
OF CHANGES HERE.

WE'VE CHANGED FROM
10 TIERS TO 6 TIERS.

THAT IS INCLUSIVE OF
ALL YOUR OFFERINGS.

WE'VE HAD A COUPLE QUESTIONS
IN THE HELP DESK ALREADY

ABOUT WHETHER OR NOT THIS
INCLUDED SUPPLEMENTAL DRUGS.

IT DOES. THOSE HAVE
TO BE INCLUDED WITHIN

ALL 6 OF THE TIERS. ALSO,
DEFINED STANDARD PLANS ARE

NO LONGER GONNA BE REQUIRED
TO ENTER THE NUMBER OF TIERS

ON THE FIRST--ON THE Rx
GENERAL 1 SCREEN.

LAST YEAR WE WERE. THIS
YEAR, YOU DON'T HAVE TO.

AND WE'VE REMOVED FROM
THE GENERAL 1 SCREEN

ANY OF THE PART D
PAYMENT DEMO QUESTIONS.

AND THROUGHOUT THE SECTION
ANYWHERE WE REFERENCED

"PART D DEMO, "
WE'VE TAKEN THAT

OUT OF ANY ON-SCREEN LABELS.

FOR ENHANCED ALTERNATIVE
PLANS, WE'VE ADDED

THIS NEW QUESTION
ABOUT WHETHER OR NOT

THE PLAN THAT YOU'RE
CURRENTLY ENTERING DATA FOR

IS YOUR BASIC PLAN.

IF IT IS, WE'VE--ENABLED
A SECOND QUESTION ASKING

IF THIS IS
YOUR PART D BASIC PLAN.

WE'VE ALSO ADDED ON TO
THE GENERAL 2 SCREEN

A QUESTION ABOUT
OVER-THE-COUNTER DRUGS.

IT IS SIMPLY AN ATTESTATION
QUESTION FOR YOU

TO MAKE SURE THAT YOU ARE
PAYING FOR OTCs

UNDER A UTILIZATION
MANAGEMENT PROGRAM.

SO IT'S JUST A "YES,
YOU DO" ATTESTATION,

JUST A REMINDER FOR YOU.

AND IT ALSO MAKES SURE
THAT WE DON'T DUPLICATE

BETWEEN WHAT YOU'RE
OFFERING IN PART D

AND WHAT YOU'RE OFFERING
AS PART C

AS FAR AS
OVER-THE-COUNTER DRUGS GO.

THAT'S THE POINT OF THAT
QUESTION.

AND THEN THIS IS
THE CHILD QUESTION

FOR THE OTCs, WHICH YOU'LL
ALSO BE REQUIRED TO ANSWER.

CONTINUING WITH ENHANCED
ALTERNATIVE PLANS,

THE PART D COST-SHARING
REDUCTION LIST

HAS BEEN MODIFIED.
LAST YEAR IT WAS 4 ITEMS.

THIS YEAR, IT'S 5.

RAISED ICL IS THE NEW
ONE THIS YEAR

THAT WE ADDED TO THE LIST.

THE OTHERS WERE
ALL THERE LAST YEAR.

THE COVERAGE GAP COST SHARES
WAS THERE LAST YEAR,

BUT I BELIEVE IT WAS WORDED
A LITTLE DIFFERENTLY,

BUT IT MEANS THE SAME THING.

FOR SPECIALTY TIERS, WE'VE
ADDED EDIT RULES IN

FOR CO-PAY AND COINSURANCE.

AND THOSE EDIT RULES HAVE
BEEN ADDED INTO THE SOFTWARE

SO THAT IF YOU
ENTER SOMETHING

THAT DOESN'T FOLLOW
THOSE RULES, YOU WILL GET

AN EXIT VALIDATION
WARNING MESSAGE.

AND THESE RULES ARE
ONLY APPLICABLE

TO THE PRE-ICL TIERS.

SO SIMPLY, YOUR SPECIALTY
TIER PRE-ICL.

WE'VE ADDED A RULE THAT IF
YOU ARE SELECTING, THAT YOU

OFFER REDUCED COST-SHARE
TIERS POST-CATASTROPHIC,

THEN YOU CANNOT--
WHEN YOU GET TO

THE CATASTROPHIC
ARROW SCREENS,

YOU CANNOT SELECT

MEDICARE DEFINED
COST-SHARING.

SO THAT'S WHERE YOU NEED TO
MAP WHAT YOU'VE DONE

EARLIER IN THE PBP,
WHERE YOU WERE LISTING

WHAT YOUR REDUCED
COST-SHARING IS,

IT NEEDS TO FOLLOW
THROUGHOUT THE SOFTWARE.

WHEN YOU GET TO
THE CATASTROPHIC SCREENS,

YOU NEED TO MAKE SURE THAT
YOU ARE OFFERING

SOME REDUCED
COST-SHARING.

THE SAME THING IS TRUE
FOR PRE-ICL

AND IF YOU SELECT THAT
YOU'RE OFFERING GAP.

ALSO, IF YOU'RE OFFERING

REDUCED PRE-ICL
COST-SHARING, AND YOU ARE

OFFERING COST-SHARE TIERS
AND THEY ARE

ALL COINSURANCE, THEN AT
LEAST ONE OF THOSE

COINSURANCE AMOUNTS IS

GONNA HAVE TO BE LESS THAN
THE 25% MEDICARE DEFINED.

THE OTHERS CAN BE 25%,
BUT AT LEAST ONE OF THEM IS

GONNA HAVE TO COME THROUGH
AS BELOW THE 25% THRESHOLD.

Part 2

WE'VE STANDARDIZED
ALL THE TIER LABEL NAMES.

LAST YEAR, YOU MAY REMEMBER,
WHEN YOU ENTERED YOUR TIERS,

THE TIER LABEL WAS JUST
AN OPEN TEXT BOX.

YOU COULD PUT IN THERE
ANYTHING YOU WANTED.

THIS YEAR, IT'S STANDARDIZED BASED
ON WHAT THE DRUG OFFERING IS.

SO FIRST, YOU'RE GONNA DEFINE
HOW YOUR DRUGS ARE OFFERED IN THE TIER,

IF IT'S A SPECIALTY TIER,
IF IT'S AN INJECTABLE ONLY TIER,

AND THEN ON THE NEXT SCREEN,

YOU'RE GONNA HAVE A PICK LIST
TO CHOOSE

WHAT THE TIER LABEL NAME IS.

EVERY TIER LABEL NAME
WILL BE THERE.

YOU HAVE TO CHOOSE
THE APPROPRIATE ONE.

WE'VE ALSO GOT GOOD VARIABLE
HELP ON THAT SCREEN.

IF YOU RIGHT-CLICK ON THE LIST,

THE PBP IS GONNA
HAVE A POP-UP COME UP

WITH EVERY SINGLE SCENARIO
OF POSSIBLE DRUG COMBINATIONS

AND WHAT THE APPROPRIATE
TIER LABEL NAMES ARE.

FOR SOME--YOU KNOW, IF IT'S
JUST A GENERIC TIER,

THEN YOU'RE GONNA
CHOOSE GENERIC,

BUT IF THERE'S
A MORE COMPLEX COMBINATION,

IT'LL SHOW YOU WHICH ONES
ARE APPLICABLE FOR YOU.

IF YOU ARE NOT SURE
OF WHAT YOU'RE DOING

AND YOU CLICK THROUGH,

YOU MAY GET AN ERROR MESSAGE.

YOU CAN JUST RIGHT-CLICK TO CLEAR
THAT SCREEN AND GO BACK,

LOOK AT YOUR DRUG OFFERING
AGAIN,

THEN GO BACK
AND DO THE VARIABLE HELP AGAIN.

SO YOU WON'T BE
LEAVING THAT SCREEN WITHOUT DOING IT CORRECTLY.

IF YOU INDICATE THAT YOU HAVE
A PART D ONLY TIER

OR A COMBINATION TIER
OF PART D DRUGS AND EXCLUDED DRUGS,

YOU NOW, THIS YEAR,
WILL HAVE THE OPTION OF LABELING THIS

AS AN INJECTABLE DRUG ONLY TIER.

THAT'S A NEW QUESTION THIS YEAR.

IT'S NOT ACTIVE FOR
EXCLUDED DRUG ONLY TIERS.

WE REMOVED THE LIMITED GAP
COVERAGE QUESTIONS

FROM THE ALTERNATIVE ICL SCREEN
ENTIRELY.

WE SORT OF COMBINED THAT
WITH OTHER QUESTIONS.

SO IT BECAME REDUNDANT.

SO LAST YEAR,
YOU MAY REMEMBER,

WE HAD AN AREA FOR YOU TO
DESCRIBE YOUR GAP COVERAGE

WITH ALL DRUGS, SOME, FEW, MANY,
NONE, FOR GENERIC AND BRAND.

WE REMOVED THAT THIS YEAR
ENTIRELY.

AND THIS YEAR,

INSTEAD OF IDENTIFYING
WHICH TIERS ARE EXCLUDED FROM GAP COVERAGE,

YOU'RE GONNA TELL US
WHICH TIERS ARE INCLUDED IN YOUR GAP COVERAGE.

AND THEN, SUBSEQUENTLY,

THE ONLY TIERS THAT ARE INCLUDED
ARE GONNA GENERATE SCREENS

FOR YOU TO DESCRIBE
THE GAP COVERAGE.

LAST YEAR, EVERY TIER
WAS INCLUDED,

BUT IF IT WAS NOT OFFERED,

THEN YOU JUST HAD TO CLICK
THROUGH THEM,

SO WE ELIMINATED THAT
CLICKING FOR YOU.

WE REMOVED THE QUESTIONS
YOU SEE ON THE SCREEN

ABOUT 100% TIER COVERING
AND ARE ALL DRUGS COVERED THROUGH THIS GAP--

ALL DRUGS ON THE TIER
COVERED THROUGH THE GAP.

WE DIDN'T REMOVE THE IDEA.

WE SORT OF REWORDED THOSE QUESTIONS AS WELL

SO THAT THE IDEA IS STILL THERE,

BTU THESE ACTUAL QUESTIONS
HAVE BEEN CHANGED A LITTLE BIT.

AND IT'S BEEN CHANGED,
AS YOU SEE ON THE SCREEN, SO...

IT INCORPORATES THE SAME IDEA,

AND WE ALSO HAVE THE LABEL
ON SCREEN DESCRIBING,

"THIS MEANS
FULL TIER GAP COVERAGE,

THIS IS PARTIAL TIER GAP
COVERAGE."

HOPEFULLY THAT'S A LITTLE
BIT MORE CLEAR FOR EVERYONE.

HERE IS THE NEW GAP COVERAGE
SCREEN.

SO YOU CAN SEE,

ARE YOU OFFERING GAP COVERAGE?
YES.

AND THEN YOU CHOOSE THE TIERS.

IF YOUR PLAN IS NOT OFFERING
ALL 6 TIERS,

YOU ARE STILL GONNA SEE
THE CHECK BOXES FOR ALL 6 TIERS.

AND IF YOU ACCIDENTALLY
CHOOSE TIER 6

AND YOU'RE ONLY OFFERING
5 TIERS,

YOU'RE NOT GONNA BE ABLE
TO LEAVE THE SCREEN.

THE PBP IS GONNA KNOW THAT
YOU ACCIDENTALLY CLICKED THAT,

SO IT'S GONNA ASK YOU
TO CLEAR THAT.

SO WE'RE NOT GONNA HAVE YOU
DOING DATA ENTRY

FOR A TIER THAT DOESN'T EXIST
FOR YOUR PLAN.

HERE'S THE NEW GAP TIER SCREEN.

AND YOU'LL SEE THE FIRST
QUESTION UP THERE IS,

ALL DRUGS OR SOME DRUGS

FOR THE FULL OR PARTIAL TIER
GAP COVERAGE.

AND THEN YOU'LL NOTICE
THE TWO QUESTIONS BELOW IT,

WHICH ARE NEW.

AND THESE QUESTIONS
ARE ONLY GONNA BE ENABLED

IF YOU'VE GOT A COMBINATION
PART D AND INCLUDED DRUG TIER.

THE FIRST ONE ASKS IF YOU'RE
COVERING ANY EXCLUDED DRUGS

THROUGH THE GAP,

AND IF YOU ANSWER YES
TO THAT QUESTION,

THEN THE QUESTION BELOW IT
BECOMES ENABLED,

AND THAT QUESTION IS,

ARE YOU ONLY COVERING
EXCLUDED DRUGS ON THAT TIER?

AND AGAIN, THAT'S ONLY ACTIVE
IF IT'S A COMBINATION TIER.

IF IT'S
AN EXCLUDED DRUG ONLY TIER,

OBVIOUSLY, IF YOU'RE COVERING IT
THROUGH THE GAP,

YOU'RE COVERING EXCLUDED DRUGS.

IN THE NOTES FIELD,

THIS YEAR, THERE'S A LIMIT
OF 225 CHARACTERS.

SO IF YOU ARE PUTTING IN A NOTE,
USE YOUR SPACE WISELY.

THOSE 225
WILL PROBABLY GO QUICKLY.

WE'VE UPDATED PLAN COPY
THIS YEAR,

OBVIOUSLY BASED ON
HOW THE REQUIREMENTS FOR THE PBP
CHANGED FOR 2011.

WE'RE NOT GONNA INCLUDE
SECTION RX DATA IN THE PLAN COPY,

AND ALSO, SECTIONS C AND D
ARE NOT INCLUDED THIS YEAR.

Part 3

TERI'S GONNA TALK ABOUT
WHAT CHANGED FOR THE SB.

Teri: THANK YOU.

MM-HMM.

OK. SO FOR 2011, A LOT OF
SB CHANGES--PROBABLY

MOST OF THEM BEHIND
THE SCENES THAT, YOU KNOW,

YOU WON'T SEE BECAUSE EVERY
TIME SOMETHING CHANGES,

IN THE PBP THAT IMPACTS
A SENTENCE, YOU KNOW,

IF A QUESTION GETS
REMOVED OR IT GETS CHANGED

OR THE ANSWERS GET CHANGED,
THEN WE HAVE TO UPDATE

THE SB CODE. BUT HOPEFULLY
THE SENTENCES, YOU KNOW,

ARE ALL PERFECT. EVERY YEAR
THE INTRODUCTIONS GET

UPDATED. SO YOU'LL SEE SOME
SLIGHTLY REVISED WORDING.

AGAIN, THOSE ARE ALL BASED
ON THE PLAN TYPE ATTRIBUTES.

A FEW CHANGES IN THE
ORIGINAL MEDICARE SENTENCES.

SOME NEW SENTENCES WERE
ADDED THIS YEAR

FOR HIV SCREENING.
CURRENTLY, YOU'LL SEE THAT

IN THE ORIGINAL MEDICARE
COLUMN, IN SB 21.

I THINK THERE MIGHT BE
A CHANGE TO THAT.

BUT IN THIS SOFTWARE,

CURRENTLY THAT'S
WHERE IT IS.

NEW SENTENCES FOR
DUAL-ELIGIBLE SNPs.

IN THE SB 1 CATEGORY, A NEW
SENTENCE HAS BEEN ADDED

IF YOU'RE
A DUAL-ELIGIBLE SNP.

THAT HAS
THE DOUBLE ASTERISK, OK,

SO IT'S INFORMING THE BENE
THAT THEY NEED TO CONSULT

WITH THE PLAN ABOUT
OUT-OF-NETWORK SERVICES.

FOR ALL THE OUT-OF-NETWORK
COST-SHARING SENTENCES

THAT GET GENERATED IN

THE PLAN COLUMN, NOW THEY'LL

ALL APPEAR WITH
THIS DOUBLE ASTERISK.

SINGLE ASTERISK FOR
IN-NETWORK,

DOUBLE FOR OUT-OF-NETWORK.

IF YOUR SERVICE AREA IS
PUERTO RICO, THEN YOU'LL SEE

SOME CHANGES
BASED ON WHETHER YOU

ARE OR ARE NOT ELECTING
TO PARTICIPATE IN

THE PLATINO PROGRAM.
SO IF YOU ARE, YOU'LL SEE

ONE VERY DIFFERENT SENTENCE.
IF YOU'RE NOT,

THEN YOU WILL JUST GET
THE REGULAR SNP SENTENCES.

THERE HAS BEEN A REQUEST
FOR A WHILE

ABOUT THE TITLES THAT GET
USED FOR SERVICE CATEGORIES.

PRIOR TO 2011, WHENEVER WE
GENERATED A SENTENCE THAT

INCLUDED A LIST,

IT WAS ALWAYS USING
THE SB CATEGORY TITLES.

SO THAT'S BEEN CHANGED,
SO NOW IT'LL REFERENCE

THE PBP CATEGORY TITLES.

SO IF IT'S LISTING
THE CATEGORY FOR EYEWEAR,

LAST YEAR IT WOULD HAVE
SAID "VISION."

THIS YEAR IT WILL SAY

"EYEWEAR. "

SO THAT'S SORT OF TO AVOID
CONFLICTS, WHERE THERE WERE

DIFFERENT COST-SHARING
FOR DIFFERENT CATEGORIES,

BUT THEY HAD
THE SAME TITLE, OK?

SO IT SHOULD--MATCH NOW
THE PBP CATEGORY TITLE.

UNDER THE OUT-OF-NETWORK--
IN SECTION "C" IF YOU CREATE

YOUR OUTPATIENT GROUPS,
YOU CAN SELECT

"NO COINSURANCE"
AND "NO CO-PAYMENT"

AND THEN YOU WILL GET
A ZERO CO-PAY SENTENCE, OK,

FOR THOSE CATEGORIES, OK?

I THINK BEFORE YOU HAD
TO ACTUALLY ENTER A ZERO,

BUT YOU DON'T NEED TO
DO THAT ANYMORE.

THE LOGIC WAS REVISED, OK?

AND THEN SOME SLIGHT
WORDING CHANGES,

LIKE A DOLLAR LIMIT WHEN YOU
INDICATE A COVERAGE LIMIT

NOW HAS BEEN SPECIFIED TO
BE "PLAN COVERAGE LIMIT,"

OK? SO A FEW LITTLE
THINGS HERE AND THERE.

THESE ARE JUST SOME OF
THE HIGHLIGHTS.

THERE'S A MUCH MORE
DETAILED LIST

IN THE LIST OF CHANGES

THAT'S UNDER
THE DOCUMENTATION LINK

ON HPMS.

FOR EXAMPLE, FOR SNFs,

IF YOU INDICATE
IN SECTION "B"

THAT YOU OFFER LESS THAN
A 3-DAY PRIOR STAY, THERE

HAVE BEEN SOME
WORDING MODIFICATIONS

FOR THE COST-SHARING
SENTENCES.

SO IF YOU SELECT "YES, LESS
THAN A 3-DAY PRIOR STAY IS

REQUIRED," BUT THEN YOU
INDICATE THAT YOU'RE USING

MEDICARE-DEFINED
COST-SHARING,

YOU'LL SEE DIFFERENT
WORDING.

IT WON'T REFERENCE A 3-DAY
PRIOR STAY ANYMORE, OK?

SO THAT SHOULD BE
PRETTY CLEAN.

PLAN SENTENCES REGARDING
HIV SCREENING WILL

AUTOMATICALLY BE GENERATED
IN THE SB-8 CATEGORY,

WHICH IS THE "DOCTOR
OFFICE VISITS."

AND A SENTENCE HAS
BEEN ADDED REFERENCING

THE MEDICARE COVERAGE
LIMIT FOR O.T. AND P.T.

IN THE DENTAL SECTION
IF YOU DID NOT OFFER

ANY MANDATORY BENEFITS BUT
YOU DID OFFER AN OP SUPP

BENEFIT, THERE WOULD BE A
SENTENCE SORT OF REFERENCING

THAT SECTION. SO TELLING
THE ENROLLEE, YOU KNOW,

"WE'RE NOT REALLY COVERING
ANYTHING,

BUT WE ARE OFFERING
SOME OPTIONAL BENEFITS."

A SIMILAR SENTENCE
HAS BEEN ADDED

IN THE VISION CATEGORY
AND THE HEARING CATEGORY.

SO IF YOU'RE
BASICALLY COVERING

WHAT MEDICARE COVERS

AND THEN YOU HAVE SOMETHING
OPTIONAL, THE ENROLLEE

WILL KNOW TO GO LOOK IN
THAT OP SUPP SECTION.

AND AS I SPECIFIED AT
THE BEGINNING, YOU KNOW,

WHEN SOMETHING CHANGES
IN THE PBP, WE HAVE TO HAVE

SORT OF THE CORRESPONDING
SB CHANGES.

AND AS TED MENTIONED, ONE OF
THE BIG CHANGES WAS ADDING

A LOT MORE QUESTIONS
TO COLLECT THE DETAILED

INFORMATION ABOUT SEPARATE
OFFICE VISIT COST-SHARING.

SO IN THOSE CATEGORIES WHERE

THAT QUESTION IS ASKED,

LAST YEAR IT WAS PULLING
THE COST SHARES FROM PCP.

THIS YEAR, IT'LL PULL THE
COST SHARES THAT YOU ENTER

IN THAT CATEGORY.

SO IF YOU HAVE A SEPARATE
OFFICE VISIT COST-SHARING

FOR ONE OF THE SCREENING
CATEGORIES AND YOU ENTERED

IN THAT CATEGORY, IT WILL
PULL THAT DATA, OK?

AND THAT'S IT.
SO YOUR CONTACT LIST.

OK. SO AS YOU CAN SEE, JUST
A VERY HIGH-LEVEL OVERVIEW

OF THE CHANGES THIS YEAR.

AS TERI AND TED INDICATED,

THIS ISN'T 100%
COMPREHENSIVE

OF ALL OF THE CHANGES,

IT'S JUST SOME OF THE MORE
HIGH-LEVEL, VISIBLE CHANGES

THAT YOU'LL
DEFINITELY NOTICE

WHEN YOU GO INTO
THE SOFTWARE THIS YEAR.

SO AT THIS TIME IF ANY
OF YOU HAVE QUESTIONS,

PLEASE COME UP
TO THE MICROPHONES.

WE HAVE THEM ON BOTH SIDES.

SO, YOU KNOW, WE WELCOME
ANY QUESTIONS YOU HAVE.

HI, SARA.
HOW ARE YOU?

I'M GOOD.
GOOD.

HOW ARE YOU?

I'M WELL.

MY NAME IS
JENNIFER TAMBLYN.

I'M FROM KAISER
FOUNDATION HEALTH PLAN

REPRESENTING
THE CALIFORNIA REGION.

AND THE FIRST QUESTION
I HAVE IS

FOR THE HIV SCREENING,
THE NEW LANGUAGE

THAT'S IN THE SB,
IT'S CURRENTLY UNDER

SB NUMBER 8,

THE DOCTOR OFFICE
VISIT FOR THE PLAN.

I'M WONDERING BECAUSE
IT'S A LAB SERVICE

AND BECAUSE WHEN YOU
REFERENCE SB NUMBER 21

IN THE ORIGINAL
MEDICARE COLUMN,

IT HAS DESCRIPTIVE
LANGUAGE,

WHY THE PLAN COLUMN
LANGUAGE WOULDN'T BE

IN THAT SAME SECTION
AS WELL.

SO IS THAT GOING
TO BE MOVED?

OR WHAT IS THE INTENT?

I DON'T KNOW IF I CAN SAY
ANYTHING DEFINITELY NOW,

BUT, YES, I MEAN, IT IS
OUR INTENT TO KIND OF LINE

THAT ALL UP AND KEEP IT
CONSISTENT.

SO WE ARE LOOKING AT
THAT LANGUAGE CURRENTLY.

SO WOULD IT BE MOVED
FROM SB NUMBER 8

IN THE PLAN COLUMN,
OR WOULD IT BE MOVED

FROM THE ORIGINAL
MEDICARE COLUMN

IN 21 TO SB 8?

IT'S PROBABLY ALL
GETTING MOVED TO--

IS IT SB 21?

21.
YEAH. SB 21.

AND, YOU KNOW, WHATEVER
THE FINAL DECISION IS

WE WILL BE DOING A MEMO
ABOUT THAT.

WE'RE LOOKING AT THAT NOW.

SO IS THERE ANY
EXPECTATION THAT

OUR COST-SHARE--
I MEAN, WHEN WE

FIRST SAW THAT
LANGUAGE, WE THOUGHT

OK, IS THIS GOING
TO SOMEHOW AFFECT

HOW OUR COST-SHARING

SHOULD BE REFLECTED

FOR DOCTOR OFFICE
VISITS AS IT RELATES

TO LAB? SO IF WE

IN THE BACK OF OUR
MINDS KNOW THAT, OK,

IT'S ALL GONNA FALL
UNDER SB 21--LAB,

THEN OUR THOUGHT
PROCESS WOULD BE,

NO, WE DON'T HAVE
TO THINK ABOUT

CONSIDERING
ANY CHANGES TO

THE COST-SHARE RANGE
IN THAT SECTION

TO REFLECT
HIV SCREENINGS.

FOR A DOCTOR
OFFICE VISIT?

RIGHT.

I MEAN, I MIGHT NEED SOME
OF THE PART C POLICY TEAM

TO KIND OF JUMP IN
ON SOME OF THIS.

BUT, I MEAN,
I DON'T THINK

THAT WAS NECESSARILY
THE INTENT.

Man: YEAH. I JUST WANT TO
CLARIFY. HIV SCREENING

CAME IN AT THE END OF
LAST YEAR VERY SUDDENLY.

AND CHANGES TO THE FU
SOFTWARE, I THINK, REQUIRE

9 MONTHS, LIKE A PREGNANCY
OR SOMETHING.

AND IT WAS JUST
TOO RAPID FOR US.

SO WE DID A LOT OF
LAST-MINUTE PATCHES.

AND ALL THE QUESTIONS
YOU'RE ASKING ARE SAYING,

"IS THERE SOME HIDDEN
MEANING

IN THESE CLASSIFICATIONS?"

AND THE ANSWER IS NORMALLY
THERE WOULD BE,

BUT IN THIS CASE, IT'S
BECAUSE IT CAME IN AT THE END.

SO YOU SHOULDN'T READ
ANYTHING INTO IT.

THE POLICY IS WHAT YOU
THINK IT IS.

IT'S A PREVENTIVE BENEFIT,
AND THINGS LIKE THAT.

BUT BECAUSE IT CAME IN
AT THE END

AND WE WERE RUSHED TO PUT
IT IN THE PBP--

AND SARA COULD PROBABLY
SPEAK MORE TO THAT

THAN I COULD--

IT JUST GOT PUT IN
A CONVENIENT PLACE.

THERE WAS NO RHYME
OR REASON TO IT.

Sara: AND THANK YOU,
RUSSELL.

THAT'S RUSSELL HENDEL
FROM PART C POLICY.

BUT, I MEAN, DO PROBABLY
EXPECT SOME GUIDANCE ON THAT

BECAUSE WE ARE STILL
LOOKING AT THAT

PREVENTATIVE-TYPE
HIV SCREENING

IN THE GRANDER CONTEXTS
OF PREVENTATIVE SERVICES.

THIS IS
LUCIA WARD-ALEXANDER

FROM CareFirst
BlueCross BlueShield,

THE LOSER
AT THE MICROPHONE.

UM, I WANT TO TALK
A LITTLE BIT ABOUT

THE COVERAGE GAP
AND WHAT'S GONNA HAPPEN

IN THE SUMMARY
OF BENEFITS FOR

THE STANDARD PLAN
AROUND WHAT EXPLANATION

ARE WE GONNA GIVE

AROUND BRAND-NAME DRUGS
IN THE COVERAGE GAP.

OR IS THERE
GONNA BE ANY?

Sara: DO YOU GUYS
WANT TO ADDRESS THAT?

OR, MAYBE ARE YOU TALKING
ABOUT THE GENERIC COVERAGE?

BECAUSE OF
THE MANUFACTURERS

THAT HOLD 50%,
BECAUSE WE'RE GETTING

A LOT OF QUESTIONS
FROM BENEFICIARIES

ALREADY ABOUT
WHAT THAT IS ALL ABOUT.

AND WE NEED TO TELL THEM
WHAT HAPPENS WHEN THEY

GO INTO
THE COVERAGE GAP.

Woman: CURRENTLY WE REALLY
CAN'T GIVE YOU ANY GUIDANCE

ON THAT. GUIDANCE IS
FORTHCOMING

FOR THIS NEW DISCOUNT
PROGRAM.

SO THE BEST WE CAN TELL
YOU IS JUST HOLD TIGHT,

AND WE'LL HAVE SOMETHING
OUT AS SOON AS WE'RE ABLE.

Jennifer: OK. I KNOW
THAT THERE'S

SOME NEW GUIDANCE
AROUND RECOMMENDATIONS

FOR COVERING
PREVENTIVE SERVICES

AND THAT CMS IS STRONGLY
RECOMMENDING

THAT PLANS COVER THEM

OR WAIVE
THE COST-SHARING

FOR CERTAIN PREVENTIVE
SERVICES

THAT ARE COVERED
UNDER MEDICARE.

AND THE QUESTION
I HAVE WAS AROUND

THE ANNUAL

WELLNESS VISIT.

WILL THERE BE ANY
CHANGES THAT COME FORTH

IN THE PBP WHERE THAT

WOULD NEED TO BE
REFLECTED, WHERE WE

WOULD NEED TO REFLECT

THAT ANNUAL WELLNESS
VISIT IN THE PBP?

WELL, THERE IS ALREADY.

THE SERVICE
THAT WOULD BE COVERED

THAT'S A PART OF
THE ORIGINAL MEDICARE

IS THE WELCOME
TO MEDICARE BENEFIT.

SO THERE'S ALREADY A WAY
TO DO THE COST-SHARING

FOR THE WELCOME
TO MEDICARE BENEFIT.

THE ANNUAL PHYSICAL EXAM
WOULD BE A BENEFIT

ABOVE AND BEYOND

THE WELCOME TO MEDICARE
PHYSICAL EXAM.

AND SO IS THERE
AN EXPECTATION THAT WE

REFLECT THAT SOMEWHERE
IN THE PBP AS WELL

IN ADDITION TO
THE WELCOME TO MEDICARE?

MY UNDERSTANDING WAS WE
WERE JUST LOOKING AT

THE, YOU KNOW, MEDICARE
PREVENTATIVE SERVICES,

SO IT'S REALLY JUST
THE WELCOME TO MEDICARE EXAM.

AND, PART C, YOU CAN
CORRECT ME IF I'M WRONG.

DALE'S GIVING ME
THE THUMBS-UP.

SO I'M GOING WITH IT.

Man: AN ANNUAL PHYSICAL
IS A COVERED BENEFIT

UNDER ORIGINAL
MEDICARE NOW.

SO, YEAH, THEY WOULD NEED--
SOMEHOW. I'M NOT SURE

HOW WE'LL DO IT--BUT IT
WOULD BE INCLUDED

AS A COVERED BENEFIT
GOING FORWARD.

[INDISTINCT CONVERSATION]

ALL RIGHT.

SUPPLEMENTAL,
I THINK.

ALL RIGHT.
MAYBE I'VE GOT THAT WRONG.

I DON'T HAVE THE LIST IN
FRONT OF ME.

I THOUGHT THE PHYSICAL WAS--
NEVER MIND.

[LAUGHTER]

Jennifer: SO WE'RE
JUST REFLECTING

THE WTM PHYSICAL
EXAM,

NOT THE ANNUAL
WELLNESS VISIT

ABOVE AND BEYOND

WHAT'S COVERED
UNDER MEDICARE.

WE'RE CERTAINLY SAYING
YOU CAN COVER THAT BENEFIT

AT ZERO IF
YOU WOULD LIKE...

Man: YES.
THAT'S WHAT I MEANT.

I THINK WHEN WE'RE
LOOKING AT THE ZERO-DOLLAR

PREVENTATIVE SERVICES
FOR MEDICARE, WE'RE REALLY

ONLY LOOKING AT
THE WELCOME TO MEDICARE EXAM.

Russell: BUT
THE ANNUAL VISIT IS

A SUPPLEMENTAL BENEFIT,
SO YOU HAVE THE RIGHT

TO ADD IT OR NOT. BUT THE
WELCOME TO MEDICARE VISIT,

BESIDES BEING
A PREVENTATIVE BENEFIT,

IT'S ONE OF, LIKE,

THE SPECIAL PREVENTIVE
BENEFITS THAT THEY WERE

ENCOURAGING
ZERO COST-SHARING

AND OTHER THINGS ON.
SO IT HAD SPECIAL STATUS.

HI. I'M MARSHA BYRNE

FROM NETWORK
HEALTH PLAN.

THIS IS A PART C
QUESTION.

ON THE PREVENTATIVE
SERVICES,

THE ADD THAT CMS
IS RECOMMENDING--

OR TELLING US WE NEED TO
HAVE NO COST-SHARING.

IS THAT IN
AN OUT-OF-NETWORK

OR IF YOU'RE A PPO,
IS THAT JUST IN-NETWORK

THAT YOU'D HAVE
ZERO COST-SHARING?

Man: YOU KNOW, WE'RE TALKING
ABOUT THAT QUESTION RIGHT NOW.

I DON'T KNOW THE ANSWER
FOR SURE.

IT'S DEFINITELY GONNA
BE IN-NETWORK.

IT'S NOT CLEAR AT THIS
POINT WHETHER WE WOULD SAY

THAT YOU WOULD HAVE TO COVER
IT AT ZERO COST-SHARING

OUT OF NETWORK ALSO.

I MEAN, WE'LL BE GIVING SOME
GUIDANCE ON THAT SHORTLY.

Part 4

JEFF WILLIAMS. CAN
YOU DISCUSS HOW

WE'LL FILL OUT
THE GAP COVERAGE

FOR THE GENERIC?

I MEAN, WILL EVERY
PLAN SELECT AT LEAST

ONE TIER TO HAVE
COVERAGE

THROUGH THE GAP?

Sara: DO YOU WANT ME
TO ANSWER THAT? OK.

THE WAY WE'RE HANDLING
IT THIS YEAR, JEFF, IS

WE'RE GOING TO
AUTOMATICALLY JUST GENERATE

THOSE SENTENCES FOR
ALL PLAN TYPES.

SO IF YOU LOOK AT THE
SUMMARY OF BENEFITS THIS YEAR,

YOU WILL SEE
ADDITIONAL LANGUAGE

FOR THAT 7%
GENERIC GAP COVERAGE.

FOR THE ENHANCED PLANS,
YOU'RE ALSO GONNA HAVE

THE GAP COVERAGE THAT YOU
MAY NORMALLY COVER

ADDITIONAL DRUGS
IN THE GAP.

AND WE'RE GOING
TO RELABEL THAT

AS ADDITIONAL GAP COVERAGE.

SO SINCE THIS 7% GENERIC
GAP COVERAGE IS KIND OF NOW

A PART OF THE DEFINED
STANDARD BENEFIT,

MUCH LIKE THE OTHER
DEFINED STANDARD SCREENS,

THERE'S NO DATA ENTRY
REALLY ASSOCIATED WITH IT

THIS YEAR.

THAT MAY CHANGE
FOR NEXT YEAR.

BUT AS OF THIS YEAR, THERE'S
NO DATA ENTRY FOR THAT.

BUT YOU WILL SEE SUMMARY
OF BENEFIT SENTENCES

REFLECTING THAT COVERAGE.

SO IF YOU HAVE
AN ENHANCED PLAN,

YOU WILL ONLY CHECK
ONE OF THOSE TIERS

FOR GAP COVERAGE

IF IT'S COVERAGE
THAT EXCEEDS THAT.

RIGHT. IF YOU ARE AN
ENHANCED ALTERNATIVE PLAN,

THE ONLY--GAP COVERAGE
YOU'RE GOING TO ENTER IS

IF YOU'RE OFFERING
ADDITIONAL GAP COVERAGE

ABOVE AND BEYOND THAT
7% GENERIC COVERAGE.

OK. THIS IS ANOTHER
SB QUESTION.

SB NUMBER 20
IS THE DIABETES

SELF-MONITORING,
TRAINING,

THE NUTRITION
THERAPY,

AND THE DIABETES
SUPPLIES.

AND THE QUESTION
WE HAVE IS

FROM 2010 TO 2011,
THE BENEFIT DESCRIPTION

FOR THAT SECTION

WAS BROUGHT IN

TO INCLUDE
RETINAL EXAM,

GLAUCOMA TESTS,
AND FOOT EXAMS,

THERAPEUTIC
SOFT SHOES.

MY UNDERSTANDING--BASED
ON DISCUSSIONS THAT

WE'VE HAD WITH CMS
IS THAT B-11, C,

IN THE PBP IS--
STRICTLY LIMITED

TO PREVENTIVE
DIABETES SUPPLIES.

SO THE BLOOD GLUCOSE
MONITORS,

THE LANCETS,
AND THE TEST STRIPS,

AND THAT'S THE
BENEFIT DESCRIPTION

THAT'S IN THE PBP.

AND THEN, OF COURSE,
THE NUTRITION THERAPY

AND THE DIABETES
SELF-MONITORING,

TRAINING.

SO THOSE 3 PIECES,
THERE'S 11, C--

AND THE OTHER
2 ITEMS

UNDER SECTION B-14
IN THE PBP.

NOW, WHERE DOES
RETINAL EXAM,

GLAUCOMA TEST,
FOOT EXAM,

AND THERAPEUTIC
SOFT SHOES FIT INTO

ALL OF THAT? BECAUSE
IT'S REFERENCED

UNDER SECTION 20,
RIGHT?

AND WE'RE PULLING
THE DATA

FROM CERTAIN AREAS
OF THE PBP FOR THOSE

OTHER AREAS THAT
I DIDN'T MENTION.

WHERE ARE WE
REFERENCING THOSE?

WHY ARE THOSE
BEING REFERENCED

IN THAT SECTION
OF THE SB IF WE'RE

NOT CALLING OUT
COST-SHARING FOR THEM?

Russell: WE DISCUSSED
THAT LAST YEAR.

HERE'S THE SOURCE
OF CONFUSION.

I THINK THERE ARE,
LIKE, 7 BENEFITS

COVERED UNDER ORIGINAL
MEDICARE FOR DIABETES.

AND IT WOULD BE LOGICAL
TO PUT ALL 7 OF THOSE

IN ONE PLACE. THE POINT IS,
AS YOU KNOW, THE PBP HAS

20 CATEGORIES. SOME
OF THEM, LIKE SUPPLIES,

HAVE THEIR OWN EXISTENCE.

AND IT'S MORE NATURAL
TO PUT DIABETIC SUPPLIES

WITH "SUPPLIES." SO WHAT'S
HAPPENED IS BECAUSE THE PBP

HAS 20 CATEGORIES, THE
7 CATEGORIES GOT BROKEN UP.

AND THAT JUST CREATES
CONFUSION FOR THIS BENEFIT.

THE CATEGORIZATION WORKS
BECAUSE ALL SUPPLIES

GO ON "SUPPLIES."
LIKE, SOMETHING

LIKE THERAPEUTIC SHOES
AND OTHER THINGS

THAT GO IN THE RIGHT PLACE.

SO THE BRIEF ANSWER TO
YOUR QUESTION IS

NO ONE'S REALLY THOUGHT
ABOUT WHAT TO DO ABOUT THAT

EXCEPT THE PROBLEM
EXISTS AND IT'S CONFUSING

AND IT'S NOT GOING TO
GO AWAY SOON

BECAUSE WE'RE NOT GONNA
CREATE CATEGORY 21--

DIABETES.

IT'S JUST ONE OF THOSE
CATEGORIES THAT NATURALLY--

AND I EMPHASIZE THE WORD
"NATURALLY, "

GETS BROKEN UP.

SO THE POINT TO EMPHASIZE
IS UNTIL WE COME UP

WITH A SOLUTION THAT

APPEARS NATURAL,

IT IS THAT YOU AS A PLAN
ARE OBLIGATED

TO FURNISH ALL 7 BENEFITS.

THOSE THAT ARE EXPLICITLY
LISTED SHOULD BE LISTED

IN THE APPROPRIATE PLACE.

AND THOSE THAT AREN'T,
YOU KNOW, YOU PUT

WHERE YOU THINK IS
APPROPRIATE.

LIKE, I GUESS PLACE 20.

SO FOR EXAMPLE,
CALLING OUT

SHOES FOR DIABETES
PATIENTS, THAT WOULD BE,

LIKE, UNDER ORTHOTICS.

RIGHT. AND THAT'S WHY
IT GOT CLASSIFIED THERE.

AS I SAID, THERE ARE TWO
WAYS TO LOOK--LET'S JUST

TAKE THAT EXAMPLE. AND
AS I SAID, WE DISCUSS PBP

ALL THE TIME. WE DON'T JUST
COME TO THIS CONFERENCE.

WE'VE BEEN DISCUSSING
IT FOR A YEAR.

AND WE ACTUALLY SPENT
TWO OR 3 HOURS LOOKING AT

DIABETES. WE WENT TO
THE MANUALS.

WE LOOKED UP EVERY BENEFIT.

AND WE HAD THIS SAME
CONVERSATION ABOUT A YEAR AGO.

AND SOMETHING LIKE SHOES,
YOU'D SAY, "WELL, IT'S

"A DIABETES BENEFIT.
IT'S ONE OF THE 7.

PUT THEM WITH ALL
THE OTHER DIABETES."

BUT THEN THE DME FOLKS,
THERE'S A DME BENEFIT.

AND, YOU KNOW, THAT'S
LIKE SHOES.

WELL, THAT'S A SUPPLY. IT'S
NOT SOMETHING YOU INJECT

OR SOMETHING. AND THEY
SAY IT BELONGS OVER HERE.

SO THERE'S NO NATURAL WAY
TO ANSWER IT.

IF WE PUT ALL
THE DIABETES TOGETHER,

WE'RE BREAKING UP
THE 20 CATEGORIES,

AND SO IT'S JUST CONFUSING.

SO IF SOMETHING
IS EXPLICIT,

LIKE WITH SHOES,
YOU PUT THEM

UNDER ORTHOTICS. IF IT'S
NOT EXPLICIT, MAKE SURE

YOU COVER IT.
MAKE SURE YOU MENTION IT

IN YOUR EOC, AND PUT IT
WHERE YOU THINK IT'S BEST.

AND IF WE EVER COME UP
WITH A DECENT SOLUTION,

WE WILL BE HAPPY TO SHARE
IT WITH THE WORLD.

BUT AS I SAID, IT'S

INTRINSIC TO THE PBP THAT

THERE WILL BE SOME AREAS,
LIKE DIABETICS, WHERE

THE BENEFIT IS SO RICH THAT
IT CROSSES OTHER CATEGORIES

WHICH ARE MUCH BROADER.

SO JUST THE LAST PIECES.
WE JUST WANT TO CONCERN

THAT, B-11, C, IS
STRICTLY INTENDED

FOR THE PREVENTIVE
SUPPLIES, THOSE SUPPLIES

THAT ARE USED TO DETECT
DIABETES B,

BUT GLUCOSE MONITORS,
THE LANCETS,

THE TEST STRIPS,
THAT'S IT.

SO NONE OF THE EXTERNAL
INSULIN PUMPS,

ALL OF THAT STUFF--
FALLS

IN THEIR
RESPECTIVE AREAS

OUTSIDE OF THE 11, C.

THAT'S RIGHT. AND AS I SAID,
AS A PLAN, YOUR JOB IS

SIMPLY TO MAKES SURE
THE BENEFICIARIES KNOW

THAT THESE 7 BENEFITS
ARE THERE.

AND YOU SHOULD MENTION IT
IN YOUR EOC.

AS LONG AS THE BENEFICIARIES
AREN'T CONFUSED,

IT DOESN'T MATTER
IF WE ARE. BUT...

[LAUGHTER]

THANK YOU.

HI. LINDA BELLGRAPH FROM
PRIORITY HEALTH.

THIS IS KIND OF
A QUESTION RELATED

TO ONE THAT WAS
ASKED EARLIER.

WHEN WE TALKED ABOUT--
I CAN'T REMEMBER

THE GENTLEMAN'S NAME
WHO TALKED ABOUT

THE CATEGORIES--
THE INPATIENT SNF,

HOME HEALTH, DME,

AND PART "B" DRUGS
YESTERDAY,

THAT HE SAID
THEY HAVE TO BE

LESS THAN ORIGINAL
MEDICARE.

AND WE HAVE THEM, LIKE,
INPATIENT IS, LIKE, ZERO

ON OUR IN-NETWORK,

BUT OUR OUT-OF-NETWORK
BENEFITS MAY BE 30%.

AND IS THAT OK?
IT'S KIND OF LIKE

THE OTHER QUESTION ON
THE PREVENTIVE BENEFITS.

YES. THIS IS
DALE SUMMERS FROM PART C.

I BELIEVE YOU'RE

REFERRING TO

BASICALLY THE
COST-SHARING STANDARDS.

YES.

Dale: AND IN THE MEMO THAT WAS
SENT OUT ON FRIDAY THE 16th--

AND I REALIZE PEOPLE
HAVEN'T REALLY HAD A CHANCE

TO ABSORB ALL
THE INFORMATION IN THERE,

BUT THERE'S A LEAD-IN
PARAGRAPH THAT DEFINES

THE FACT THAT THERE'S
COST-SHARING STANDARDS

APPLIED TO IN-NETWORK
SERVICES FOR LOCAL PPOs

AND REGIONAL PPOs.

Lynda:
OK. THANK YOU.

YOU'RE WELCOME.

HI. I'M ROB BAUER

WITH MARION POLK
COMMUNITY HEALTH PLAN.

I GOT A QUESTION
REGARDING

THE PART D
BASIC BENEFITS,

WHEN YOU ALSO ARE
GONNA OFFER

AN ENHANCED ALTERNATIVE
BENEFIT AND YOU ANSWER

YES OR NO, IS THIS
THE BASIC BENEFIT,

OR IS THIS ENHANCED
ALTERNATIVE--

WHERE THE SUPPLEMENTAL
SERVICES ARE GONNA

BE BOUGHT DOWN TO ZERO--

IF YOU DO HAVE
A BASIC BENEFIT

WITHIN THE CONTRACT,
CAN THAT BASIC BENEFIT

BE A SNP? THE NEXT PART
OF THAT QUESTION

THAT I HAVE IS

THE REQUIREMENT
PER CONTRACT.

SO IF WE HAVE MULTIPLE
CONTRACTS,

IN EACH CONTRACT
WE HAVE TO HAVE

AT LEAST ONE PART D
BASIC BENEFIT

OR HAVE OUR ENHANCED
ALTERNATIVE BUY DOWN

THE SUPPLEMENTAL
SERVICES TO ZERO?

Woman: IT'S WITHIN
A SERVICE AREA?

IT'S WITHIN
THE SERVICE AREA.

WE GOT TWO CONTRACTS.
ONE'S A LOCAL PPO,

ONE IS AN HMO.
EACH ONE HAS

AN ENHANCED
ALTERNATIVE BENEFIT.

AND SO I WAS WONDERING,
IS THE REQUIREMENT

PER CONTRACT NUMBER?

YES. IT'S PER CONTRACT
WITHIN THAT SERVICE AREA.

SO IF ONE HAD A BASIC UNDER
THE SAME PARENT ORG...

YEAH.

THEN THAT BASIC COULD SATISFY
FOR THE OTHER CONTRACTS

THAT DIDN'T
IN THE PAST.

Rob: VERY NICE.

THE BASIC OR THE B.A.,

WHICH HAS A SUPPLEMENTAL
PREMIUM OF ZERO.

Rob: SO MY OTHER
QUESTION

ABOUT IF THE SNP

CAN SATISFY THAT BASIC
BENEFIT REQUIREMENT,

SHOULD I E-MAIL
THE PART D IMPL MAILBOX?

OR...

YOU MEAN FOR YOUR
FIRST QUESTION?

YES.

NO. I WOULD GO AHEAD
AND E-MAIL

THE PART D BENEFITS
MAILBOX AT

partdbenefits@cms.hhs.gov.

OK. THANKS.
YES.

Jennifer: SO THE
NEXT QUESTION I HAVE

IS MORE OF
A POLICY QUESTION

AND LESS AROUND THE
PBP FUNCTIONALITY.

SO ON THE
APRIL 16th GUIDANCE

THAT WAS RELEASED ON
BENEFITS POLICY

AND OPERATIONS, THE
VISITOR/TRAVEL BENEFIT,

I JUST WANTED TO CLARIFY
WHETHER THAT REQUIREMENT

STRICTLY APPLIES
TO PLANS THAT OFFER

A VISITOR/TRAVEL BENEFIT
FOR MEMBERS WHO ARE

OUTSIDE OF THE SERVICE
AREA FOR LONGER

THAN 6 MONTHS.
SO IF YOU PROVIDE

A VISITOR/TRAVEL BENEFIT

FOR A PERIOD SHORTER
THAN 6 MONTHS,

ARE WE STILL SUBJECT TO
THOSE NEW REQUIREMENTS?

Man: THE ANSWER
TO THAT QUESTION IS,

I MEAN, YOU DON'T HAVE
TO DISENROLL SOMEBODY

IF THEY'RE OUT OF YOUR
SERVICE AREA CONTINUOUSLY

FOR LESS THAN 6 MONTHS.

SO TECHNICALLY SPEAKING,
YOU DON'T HAVE TO PROVIDE

A VISITOR/TRAVEL BENEFIT
AT ALL. BUT IF YOU HAVE

ENROLLEES THAT YOU WANT TO
RETAIN FOR UP TO 12 MONTHS

CONTINUOUSLY OUT OF
YOUR SERVICE AREA,

IN THAT INSTANCE YOU
DO HAVE TO HAVE

A VISITOR/TRAVELER BENEFIT.

Jennifer:
OK. KAISER'S IN

KIND OF
A UNIQUE SITUATION

IN THAT WE OFFER

A VISITOR/TRAVEL
PROGRAM

FOR MEMBERS--NOT ONLY
MEDICARE MEMBERS,

ALL PLAN MEMBERS--WHEN
THEY'RE VISITING

OTHER KAISER REGIONS.
AND THAT'S SOMETHING,

IT DOESN'T EXTEND ALL
THE WAY UP TO 12 MONTHS.

IT'S TEMPORARY. IT ONLY
GOES UP TO 6 MONTHS.

SO THEY'RE OUTSIDE.

WELL, YOU CAN
CERTAINLY DO THAT.

AND WE WOULDN'T BE
REQUIRED TO APPLY

MEDICARE A-B,

MANDATORY AND
OPTIONAL/SUPPLEMENTAL

DURING THAT TIME PERIOD?

NOT UNLESS YOU WERE

INTENDING TO KEEP

THOSE PEOPLE ENROLLED
UP TO 12 MONTHS.

OK. THANK YOU.

RIGHT.

Part 5

HI. I'M BACK
AGAIN, TOO.

I HAVE A QUESTION

THAT'S MORE OF
A POLICY QUESTION.

WE HAVE A PPO. AND WE
WANT TO INCENTIVIZE

PEOPLE TO GO TO GET
THEIR PRIMARY SERVICES.

SO WE WANT TO REDUCE
THE CO-PAY

FOR THOSE SERVICES.
AND I'M INTERESTED

IN KNOWING,
HOW DO YOU DEFINE

THE PRIMARY CARE
SERVICES FOR A PPO?

Man: WELL, I MEAN, A PPO
IS A COORDINATED CARE PLAN.

SO YOU COULD HAVE
PRIMARY CARE PHYSICIANS

THAT PEOPLE SELECT.
AND I'M NOT SURE EXACTLY,

BUT YOU COULD HAVE
REFERRAL REQUIREMENTS

WHEN THEY GO SEE
IN-NETWORK SPECIALISTS,

ALTHOUGH IF SOMEONE GOES

TO AN IN-NETWORK SPECIALIST

WITHOUT A REFERRAL,
THEY'RE HELD HARMLESS

BECAUSE WE ASSUME THAT
THE CONTRACTED SPECIALISTS

STAND IN THE SHOES OF
THE PLAN.

BUT A PPO IS
A COORDINATED CARE PLAN.

SO FOR YOUR PREFERRED
NETWORK, YOU COULD OPERATE

SOMEWHAT LIKE WE WOULD SAY
AN HMO COULD OPERATE.

NOW, THE REAL
DIFFERENCE GOES

WHEN THEY GO
OUT-OF-NETWORK...

RIGHT.

THERE YOU CAN'T HAVE,

REALLY,
ANY STRINGS ATTACHED.

WHAT YOU WOULD WANT TO DO,
THOUGH, IS MAKE AVAILABLE

AN ADVANCE DETERMINATION
OF COVERAGE UPON REQUEST

IF A MEMBER OR A PHYSICIAN
HAS SOME QUESTION

OR CONCERN ABOUT WHETHER
A PARTICULAR SERVICE

THEY'RE GETTING IS
EITHER MEDICALLY NECESSARY

OR COVERED BY YOUR PLAN.

SO COULD WE DEFINE

THE PRIMARY CARE
SERVICES

BY, LIKE, A PARTICULAR
TYPE OF SPECIALTY,

LIKE YOUR
FAMILY PRACTICE,

YOUR INTERNAL MEDICINE,

AND THEN PUT THAT IN
THE PBP TO EXPLAIN

WHAT OUR PRIMARY CARE IS
FOR OUT-OF-NETWORK?

I'M NOT ENTIRELY SURE I'M
UNDERSTANDING YOUR QUESTION.

WELL,
MY QUESTION IS,

WHEN I FILL OUT
THE PBP,

DO I HAVE TO PUT
A DEFINITION OF WHAT

THAT PRIMARY CARE IS
IN THE NOTES SECTION

IN THE PBP

FOR OUT-OF-NETWORK
PRIMARY CARE?

WELL, NOT FOR
OUT-OF-NETWORK.

THE INDIVIDUAL COULD GO
TO ANY PROVIDER THEY WANT.

THEY COULD GO TO
A SPECIALIST.

AND IF THEY WANTED
TO MAKE THAT

THEIR PRIMARY CARE
PHYSICIAN,

THEY COULD DO THAT.

I MEAN, THERE IS NO--
THEY CAN GO TO ANY PROVIDER

THEY WANT TO. YOU CAN HAVE
DIFFERENTIAL COST-SHARING

DEPENDING ON THE PROVIDER
THEY GO TO,

THE CATEGORIZATION
OF THE PROVIDER,

BUT YOU CAN'T DIRECT THEM
TO PARTICULAR PROVIDERS.

RIGHT. RIGHT.

DOES THAT ANSWER
YOUR QUESTION?

I THINK SO.
THANK YOU.

OK. THIS IS MY
LAST QUESTION.

AND THEN I'LL JUST BUG
YOU THROUGH E-MAIL.

HA HA! OK. SO WITH
ALL OF THE NEW

COVERAGE REQUIREMENTS,
CAN WE EXPECT TO RECEIVE

ANY PBP PATCHES,
PBP-SB PATCHES

IN THE NEAR FUTURE?

Sara: WE'RE NOT PLANNING
ANY AS OF RIGHT NOW.

I CAN'T, YOU KNOW,
NECESSARILY SAY FOR CERTAIN

THAT NOTHING WOULD HAPPEN,
BUT AS OF RIGHT NOW,

WE DON'T HAVE
ANY PATCHES PLANNED.

OK.
THANK YOU.

HI. I'M DAWN FROM

GROUP HEALTH IN SEATTLE.

AND I HAVE A SIMILAR
AND CLARIFYING QUESTION

AROUND
THE TRAVEL BENEFIT.

LIKE KAISER, WE HAVE
A VISITOR/TRAVEL BENEFIT

FOR 6 MONTHS OR UNDER.

I HAVE A TWO-PART
QUESTION.

WE CURRENTLY HAVE
A CAP LIMIT ON

HOW MUCH WE PAY

WHEN YOU'RE OUT
OF THE NETWORK.

SO I'M WONDERING UNDER
THE NEW POLICY IF THAT

WOULD STILL BE ALLOWED.

Man: WELL, I MEAN,
REMEMBER, IF YOU'RE COVERING

FOR UNDER 6 MONTHS,
YOU NO LONGER CALL IT

A VISITOR/TRAVELER BENEFIT.
PERHAPS YOU'D CALL IT

A POS BENEFIT, YOU KNOW,
BECAUSE NORMALLY IF YOU

DON'T HAVE ANY KIND OF
VISITOR/TRAVELER BENEFIT

WHEN INDIVIDUALS ARE OUT
OF YOUR SERVICE AREA--

UNLESS YOU'RE A PPO--
YOU'RE ONLY REQUIRED

TO COVER EMERGENT
AND URGENT SERVICES.

SO IF YOU WANT TO

CALL SOMETHING

A VISITOR/TRAVELER BENEFIT,

THEN THAT'S NOW A DEFINED
BENEFIT THAT REQUIRES

YOU TO PROVIDE THE FULL
BENEFIT PACKAGE ESSENTIALLY

TO ALLOW PEOPLE TO STAY IN
YOUR PLAN UP TO 12 MONTHS.

IF YOU WANT TO OFFER
SOMETHING LESS

FOR PEOPLE WHO ARE OUT
FOR SHORTER DURATIONS,

THEN YOU WOULD CALL IT
SOMETHING ELSE.

I MEAN, PROBABLY
A POS BENEFIT WOULD BE

THE MOST APPROPRIATE
CATEGORIZATION FOR THAT.

BUT IT WOULD OBVIOUSLY
NO LONGER BE

A VISITOR/TRAVELER.

OK. AND THAT
SATISFIED

MY SECOND
QUESTION.

SO THANK YOU.

ARE THERE
ANY OTHER QUESTIONS?

BECAUSE IF NOT, WE'LL GO
AHEAD AND CLOSE OUT

THE SESSION. BUT...

ARE--OK. GREAT. THANKS.

HI. I'M SEAN ROYCE WITH
CLARIAN HEALTH PLANS

IN INDIANA. I HAVE
TWO QUESTIONS.

ONE IS THE NOTES
SECTION WE USE

TO FURTHER CLARIFY

SOME OF OUR BENEFITS.
AND IT DOESN'T SHOW UP

ON THE SBs.

IS THAT POSSIBLE
THAT WE COULD GET THAT

TO HAPPEN? JUST
A RHETORICAL, I GUESS.

Sara: SURE. WELL, THE NOTES
SECTION, AS YOU KNOW,

IS A TEXT FIELD. SO THE WAY
YOU ENTER THAT LANGUAGE

IN THERE MAY NOT
BE SB-LIKE.

WE CAN'T REALLY MANIPULATE
SENTENCES

FROM FREE-FORM TEXT BOXES,
SO THOSE NOTES CURRENTLY,

AS YOU KNOW, DON'T
POPULATE ANYWHERE

IN THE SUMMARY OF BENEFITS.

MY UNDERSTANDING IS THAT
WITH ANYTHING THAT YOU ARE

ENTERING IN THE NOTES, YOU
SHOULD ONE--ONLY BE ENTERING

INFORMATION THAT'S
CLARIFYING YOUR BENEFIT

THAT YOU CURRENTLY HAVEN'T
ENTERED IN THE PBP.

AND THEN YOU CAN ALSO USE
THAT INFORMATION AND PUT IT

IN, LIKE, SB SECTION 3
TO FURTHER CLARIFY

YOUR BENEFIT. BUT THERE'S
NO DISCUSSION OF REALLY

TRYING TO CREATE, YOU KNOW,
AUTOMATED SENTENCES

OFF OF THAT FREE-FORM
TEXT BOX.

OK. THANK YOU.
MY SECOND ONE IS

I APPLAUD YOUR
EFFORTS

FOR MAKING
THE DISCONNECT

BETWEEN THE PBP
AND THE SB.

IS THERE ANY PLAN
TO MAKE THOSE--

YOU KNOW
WHAT I MEAN.

THEY HAVE
DIFFERENT NUMBERS.

AND THE SECTIONS,
AS WE HEARD BEFORE,

THE DIABETES IS SPREAD
ALL THROUGHOUT.

IS THERE ANY WAY
WE COULD MAKE

THOSE THE SAME BEYOND
JUST, LIKE, CHANGING

THE EYEWEAR
FROM "VISION"?

ARE YOU TALKING
ABOUT, LIKE, THE ORDER

THAT THE SB GENERATES?

WELL, THEY HAVE

DIFFERENT NUMBERS,
AS YOU KNOW.

LIKE, THERE'S
SECTION 8--

OR 9, I THINK, MIGHT
BE PREVENTATIVE,

YET IT'S SECTION
20-SOMETHING

ON THE SB.

RIGHT. I MEAN, THE WAY
THAT WAS SET UP--AND THIS

CERTAINLY PREDATES MY TIME
JOINING CMS--BUT I THINK IT

WAS SET UP IN THAT FORMAT
FOR A PARTICULAR REASON,

BECAUSE THERE'S
CERTAIN INFORMATION

WE WANT TO DISPLAY IN
A CERTAIN ORDER

IN THE SUMMARY OF BENEFITS.

I GUESS, YOU KNOW, THAT'S
SOMETHING WE CAN CERTAINLY

RE-LOOK AT. BUT THE ORDER
THAT THE SENTENCES GENERATE

WERE PURPOSEFULLY DONE IN
THE WAY THAT THEY ARE

CURRENTLY DISPLAYING.
WE DIDN'T JUST, YOU KNOW,

PUT THEM IN ANY SORT
OF ORDER.

I MEAN, AS YOU WOULD
IMAGINE,

THE PREMIUM AND IMPORTANT
INFORMATION,

WHICH IS SB SECTION ONE

AND THE SECTION TWO,
SUMMARY OF BENEFITS--

THAT'S SOME OF YOUR MORE
IMPORTANT INFORMATION

THAT BENES ARE REALLY GONNA
BE INTERESTED IN SEEING.

SO WE'VE TRIED TO LAY IT OUT
IN A WAY THAT WOULD BE

MOST BENEFICIAL FOR PEOPLE
WHO ARE LOOKING AT

THE SUMMARY OF BENEFITS.

BUT, YOU KNOW,
WE CERTAINLY CAN RE-LOOK

AT THE ORDER AND
SEE IF THERE'S ANYTHING

THAT SEEMS TO MAKE SENSE
TO BE IN A DIFFERENT WAY.

WE DO HAVE THE PBP-TO-SB
CROSSWALK DOCUMENT,

SO YOU CAN SEE WHICH
PBP CATEGORIES LINE UP

WITH THE SB CATEGORIES.

SO IF NOTHING ELSE, THAT
SHOULD, YOU KNOW, HELP YOU

A LITTLE BIT UNDERSTAND
THE CORRELATION

BETWEEN THE PBP AND THE SB.

Dale: SARA, I DID HAVE
A CLARIFYING COMMENT

TO MAKE ABOUT
A QUESTION EARLIER

ABOUT COST-SHARING STANDARDS
AND THEIR APPLICABILITY

TO IN-NETWORK. THERE ARE
TWO TESTS--TWO LARGE TESTS

FOR COST-SHARING FOR PART C.

ONE IS THE ACTUARIAL
EQUIVALENCE TEST,

WHERE THE DATA COMES
FROM THE BPT--

THE BID PRICING TOOL.

AND THE OTHER COMES FROM
BASICALLY THE PBP.

AND AS FAR AS
THE IN-NETWORK,

THE PARAGRAPH I WAS
REFERRING TO,

LEADING INTO IT, APPLIES
TO THE SERVICE CATEGORY

STANDARDS THAT ARE
TESTED FROM THE PBP DATA.

REGARDING THE ACTUARIAL
EQUIVALENCE TESTS,

MY SUGGESTION WOULD BE
TO BASICALLY LOOK AT

THE BID PRICING TOOL,
WORKSHEET 4,

AS FAR AS WHERE THOSE
COLUMNS ARE GRABBED

SO THAT IT CAN SORT OF
INFORM YOUR QUESTIONS

REGARDING THOSE TESTS.

AND TO THE EXTENT
THAT THERE ARE

QUESTIONS RELATED
TO HOW THE ACTUARIES

WOULD BE BUILDING
THE BID PRICING TOOL

INFORMATION FOR YOUR
PLAN, IT MAY BE HELPFUL

FOR YOU TO CONTACT
THE ACTUARIAL USER,

WHICH I BELIEVE

THEY HAVE THOSE
USER GROUP CALLS

TOMORROW, IF
I'M NOT MISTAKEN.

SO WHEN IT COMES TO

THE ACTUARIAL
EQUIVALENCE TEST

AND ANY SPECIFIC
QUESTIONS RELATED

TO THE BID PRICING TOOL,

THAT MIGHT BE A GOOD
FORUM TO GET AN ANSWER

TO THAT PARTICULAR
QUESTION. THANKS.

OK. SINCE WE DON'T SEE
ANYBODY ELSE STANDING

AT THE MICROPHONES, I JUST
WANT TO SAY THANK YOU AGAIN

FOR COMING TO
THE ADVANCED TRAINING.

IF YOU GUYS DO HAVE
QUESTIONS THAT COME UP

LATER ON, CERTAINLY
FEEL FREE TO CONTACT ME

AND THE APPLICABLE PART C
AND PART D CONTACTS.

AND HAVE A GOOD AFTERNOON.
THANK YOU.

[APPLAUSE]