FTS-HHS HCFA

Moderator: Mr. Eric Lang
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1:30 pm CT

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode.

During the question and answer session, please press star 1 on your touchtone phone.

Today's conference is being recorded. If anyone has the objections, you may disconnect at this time.

Now I will turn the meeting over to Ms. Susan Hollman. You may begin.

Susan Hollman: Hello and welcome to the National Medicare Training Program audio call. Today we are focusing on issues relating to open enrollment. We have pooled together a group of subject matter experts on a variety of topics.

Unfortunately, we were not able to have the Medicare Prescription Drug Plan Finder expert available today. If you do have any questions on Plan Finder, please email them to mpdpf_inquiries@cms.hhs.gov and they will get back to you themselves.

Right now we are going to start by going around the room so that the experts in the room can identify themselves and their area of expertise.

(Tracey Baker): Hi my name is (Tracey Baker), and I am expert for Low Income Subsidy, Redeeming, Best Available Evidence and Data Outlook and Custody (Datasa) Plans.

Kay Pokrzywa: Kay Pokrzywa, Low Income Subsidy.

(Lynn Orlosky): (Lynn Orlosky), Medicare Advantage and Part D Enrollment and Eligibility Policy.

(Kristi Nishimoto): (Kristi Nishimoto), Reassignment.

(Chevell Thomas): (Chevell Thomas), Marketing.

Camille Brown: (Camille Brown), Marketing.

Christopher Powers: Christopher Powers, Part D Plan Options and Performance Rating.

Carol Eaton: Carol Eaton, Enrollment Operations.

Deborah Hunter: Debbie Hunter, Point of Sale Facilitated Enrollment and (FPOT) Sheet.

Susan Hollman: Okay and we have some experts on the phone. Could you please identify yourself?

(Elizabeth Goldstein): (Elizabeth Goldstein), Part C Plan Ratings.

Greg Dill: This is Greg Dill from the Part D Drug Policy Group.

Susan Hollman: Okay.

(David Santana): (David Santana) (unintelligible) Medicare of the Patient.

Susan Hollman: All right. Thank you everyone for being here. We had asked people to send in some questions to our mailbox. So we are going to start with the questions that were emailed in, and when we are finished with those we will open the lines up to the other questions that you may have.

One of the first questions that we had, the expert could not be here but I will respond to the question.

We had a question that said how do I know when new regulations are out and where can I go on the Web to research the information?

And you should go to cms.hhs.gov. Under site tools and resources you would choose mailing list. There are a number of mailing lists on a variety of topics and you would get updates on what is happening in those areas.

To research, you can go to cms.hhs.gov and at the top, one of the choices is regulations and guidance. And you can look there if you want to research something specific.

Another question that we had received was should a Medicare participant switch from his or her current Medicare supplement plan J to one of the Medicare Advantage Plans. This is not exactly grammatically correct but I did not write it, I am sorry. Will the individual be able to switch back to the

Medicare Supplement at a future date without having to answer any medical questions?

And the answer is if the individual switching from a Medigap policy is enrolling in a Medicare Advantage Plan for the first time, the person will get a 12 month trial period which would allow him or her to go back to the old Medigap policy without being rerated based on health status if the MA plan is terminated within 12 months of enrollment.

The person would have up to 63 days past the effective date of the termination of the MA plan to reenroll in the Medigap policy.

Now another question that we had received, Greg Dill is going to respond to. So Greg could you please respond to the question that you had received?

Greg Dill: Sure. We got a question. It looks like it came in from Wisconsin specifically regarding a specific suppository that the beneficiary could not find if this product was on the drug plans formulary, and was using Plan Finder and trying to find one that was.

I guess in general I would just like to answer the question in general first. If a beneficiary needs a specific prescription drug and does not see it on the formulary, they can always request a formulary exception of the plan, or current plan or perspective plan. They can request that exception.

If it is not granted and they want to appeal that with the assistance of their physician, they certainly can do that.

Now this particular product in question is a drug that is actually not approved by the FDA and so it does not meet our definition of a Part D drug, and

therefore a Part D sponsor cannot cover this particular product that was forwarded to me.

So, again in general though, you know, it is always good to look for that formulary exception, and if necessary appeal for that coverage if they and their physician believe they want it.

But the very particular product that was forwarded in this specific email, this suppository, is actually not approved by FDA and cannot meet then therefore the Part D drug definition. So I will turn it back.

Susan Hollman: Okay thank you Greg. Okay. Kay Pokrzywa has a few questions that we have asked her to answer. So Kay?

Kay Pokrzywa: Okay. The first of these questions, the one about credible coverage, I recommend it be forwarded to (Tim Mayhue) so I am not going to attempt to answer that one.

On the second one, Debbie did you want to address question number one?

Deborah Hunter: Question number two you mean? The (unintelligible)?

Kay Pokrzywa: Right.

Deborah Hunter: Okay.

Kay Pokrzywa: Under question number 2 there are actually three questions.

Deborah Hunter: Right, right, right. Okay. It is actually a very lengthy question so, I am not read the entire question. I am going to rephrase it. But it is basically the

individual is expressing some concern over pharmacists in areas throughout the country.

Some of them do not seem to be aware of the point of sale facilitated enrollment process. And although we have done quite a bit of outreach over the past couple of years, we are still currently doing outreach at pharmacy conferences and also targeted outreach if we are aware of a specific area in the country that perhaps has more LAS, may have more LAS (sinnies) in the area or maybe has more independent pharmacies who are not in the networks who have received education on point of sale.

But I am not sure who sent this. If I could get that information perhaps from whomever sent this and I can reach out to that particular pharmacy or the actual - actually this also involves the plan too.

There was concern over certain PDPs and MAPs not understanding what is considered best available evidence for dual eligibility. They did issue a memo October 16 I believe that provides more detailed information and some updates on what we considered the best available evidence that if you need, if you are unable to find that on our Web site, you can email me a Deborah.hunter, that is D-E-B-O-R-A-H dot hunter at cms.hhs.gov I would be happy to help you.

And some other concerns in this question that were raised related to third party coverage, I am assuming that might include RDS and other types of coverage that are for some reason not being reflected in our system and if someone has been auto-enrolled or they used point of sale to kick them out of that, we are still developing some system edits and processes to prevent that from happening.

We still have a ways to go on that. 2009 hopefully that will improve as a result of some systems changes we are making. Of course if you have specific cases, bring it to the attention of your RO case worker or one of us here today and we will help you with those specific cases.

We do realize that is still a struggle for us. Sometimes the RDS state and other types of third party coverage data that we have access to is not too reliable so it is a challenge for us.

Kay Pokrzywa: One more comment. If CMS does not have any relationship with the third party coverage, there is no way CMS can know about it. Obviously we know about the plans that receive our RDS from us, but there are many employer plans out there that do not receive any subsidy from us.

So we would take one look at that particular beneficiary, have no knowledge of their third party coverage and auto-enroll them. The auto-enrollment notice does include information about dis-enrolling from that plan if the individual does not want to be in that plan.

And we certainly encourage folks with third party coverage to consult their benefit coordinator when they receive any sort of notice that they are enrolled in a Part D plan just to find out what the impact would be on their third party coverage.

Deborah Hunter: Well then I think that covers the questions that - if I did not cover everything they can contact me.

Susan Hollman: Okay, thank you very much. (Tracey Baker) is now going to respond to a question about LIS.

(Tracey Baker): Thank you Susan. I will just read the comment or the question. It says that it appears that people on LIS are being required to pay part of the plan's deductible.

Their cost for prescription and the plan are higher the first month or couple of months on the Plan Finder. I was not aware this was happening. Any help with clarification would be appreciated.

This seems to be a specific case, but in general, I would say that not everyone has zero deductible when they have low income subsidy. Remember that there are individuals that are full duals and SSI only that are deemed and they have the zero deductible.

But there are also are individuals who applies to SSA and they are awarded low income subsidy based on their income and resources. And in some cases, those people have a reduced subsidy, meaning that they will pay a reduced deductible and maybe not the one in three co-pay or the two and the five. They can potentially pay up to 15% of the cost of the drug.

So, this may be a case like that without specifically knowing what this person has and that sort of thing, you know. But what it sounds like to me is that this person may be an LIS applicant with sort of a partial or more partial subsidy than the entire zero deductible and that. Okay?

Woman: Thank you.

Susan Hollman: Thank you Tracy. (Lynn) do you have some questions (unintelligible)?

(Lynn Orlosky): Sure. I have two questions. One question had to do with explaining the, we sometimes call it the OEP New, but it is the Open Enrollment Period for

Newly Eligible Individuals. I mean, person asking the question asked for an example to when it would apply, and also asked for us to provide the A and B, Part A and B effective dates in the example.

And I think the, just to kind of give some context, the open enrollment period for newly eligible individuals is something that has been in existence for several years.

And it is - what, the purpose of it is to mirror what happens in January through March for the, you know, the general population for individuals who are Medicare Advantage, eligible to make changes once the annual election period is over in December.

And essentially what this does is for people who become eligible for Medicare Advantage during the year, giving a similar three-month period following that timeframe to make a change if they made something and they choose - if they want something different.

So in this example - this can be found in our guide. And (unintelligible) again since we are talking probably to partners and not health plans, this, you know, generally, the how, you know, partners do not generally go to our health plan guidance for this information.

This would be - an example would be someone who let us say signed up for Part B during the general - Part B general enrollment period. And their effective date for Part B would be July 1. So know they have those Parts A and B as of July 1.

The open enrollment period for newly eligible individuals basically allows individuals to make a MA election in the timeframe following the month that they are entitled to both Part A and B, and it ends three months after that.

So for this example they are entitled to A and B on July 1. And so the three months open enrollment period would then be July, August and September. So would end September 30.

And again, the reason why in our guidance it does not extend past December 31st is that the general Medicare Advantage enrollment period begins January and goes from January through March for everyone.

The second question that I received had to do with a - some - the questioner asked if someone enrolls in a Part D plan or changes plans during the open enrollment period, which I am going to assume means the, you know, the fall's Medicare open enrollment period that goes from November 15th to December 31st, can the individual change their mind and enroll in another plan before open enrollment ends?

And the question is yes. They most definitely can make it, you know, they can change their minds and basically they just need to make sure that they submit in their enrollment request to their plan. They can do that through the online enrollment center, directly, you know, sending a paper application to the plan or if that plan offers telephone or Internet enrollment doing one of those ways.

But the enrollment request needs to be received by the plans by December 31st. And I think most plans actually stay open or have their enrollment, you know, operations open until midnight of their, you know, of that day.

And so as long as your application is received by that day you can, you know, obviously you can make a change.

There was a second part of the question. I think this was actually answered by (Jim) on a previous question. You know, well actually maybe it wasn't. Is the same true for Medigap policies?

And I am not actually sure actually what the cancellation or change rules are for Medigap policies. So that is something that maybe we can follow up and answer at the next call.

Man: We will get an answer. All the questions that were submitted will get answered through the Webs...

(Lynn Orlosky): Okay.

Man: ...you know, through the resource box.

(Lynn Orlosky): Okay.

Susan Hollman: Okay. Do any of the other experts, or any of the experts on the line have any questions that they have been given ahead of time that they want to answer?

Coordinator: Were you ready to take questions?

Susan Hollman: Yes, I think we are ready to open the line.

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question, please press star 1. You will be prompted to record your name. To withdraw your request, press star 2.

Once again to ask a question, please press star 1. One moment.

(Donald Prebus) you may ask your question.

(Donald Prebus): Yes. I am wondering - I know your expert on the database, the online database is not there, but I am wondering, do you have any tips for helping people calculate when they are going to run into the doughnut hole, when you are helping them compare plans and you have their list of medications entered into the system.

Woman: I was - I am not an expert. I am definitely an expert. But I do - I am looking at a fact sheet now and it says that the Plan Finder's total monthly cost estimator would break down the estimated annual cost into monthly estimates.

(Donald Prebus): Well let me ask another question then. From what I gather, the threshold amount is calculated based upon what the Plan is paying for the drugs as well as what the beneficiary is paying in co-pays. Both are taken into account in getting to that threshold amount. Am I correct in that?

Woman: I really do not want to hazard a guess at this. I - what we can do, we will have these questions and we will - when we post the transcript, what we can do is we can provide answers to the questions that we cannot answer.

(Donald Prebus): Um-hmm. Okay.

Woman: So we will take that back to our Plan Finder folks and we will have that answer there.

(Donald Prebus): Thank you.

Woman: Thank you.

Coordinator: (Terry Gandell) you may ask your question.

(Terry Gandell): Hi. I have a question. Because we are getting some conflicting information about this, are Plans able to make changes in their formulary, their tier levels, their premiums, any of that stuff once open enrollment has started?

Greg Dill: This is Greg Dill. I will see if I can take a look at your question. Basically, once the formularies are submitted and approved by CMS, they are locked down for the first 60 days. So no changes really can occur to their formularies at all until early March, you know, for particularly the beneficiaries.

And even there we have a number of policies around making formulary changes. For instance, a certain type of change that we might refer to as a negative change or a maintenance change, in general when those type of changes occur, the beneficiaries already enrolled would be grandfathered for let us say that formulary drug for the rest of the year.

So in general again, you know, formularies are a really lock down for the first 60 days. And then there are a number of protections for any modifications that may occur after that point. Does that help?

(Terry Gandell): Yes. Does that also apply to whether or not their zero premium LIS plans?

Greg Dill: That I do not know. I mean, well I think in general, all that what I just spoke to is for all formularies across the entire program. Is there a specific question regarding LIS? Do you mean like would co-pays change for an LIS beneficiary?

(Terry Gandell): We just had somebody who was enrolled in one of the plans that was listed as a zero premium LIS plan, but they got a blue reassignment letter. And when we called to follow up, Medicare first said that it was not LIS and then they said they were. So we were just a little confused.

It is possible they just got the letter by mistake, but...

Greg Dill: Is there anyone else on the - here from CMS that could address the letter perhaps?

Woman: (Terry) did you send a question to the mailbox earlier?

(Terry Gandell): Yes.

Woman: Okay yes. We have actually seen this question and we want to do some research into it and then get back to you specifically about it.

(Terry Gandell): Okay. And I also just had a quick comment on the business about the deductible that somebody asked earlier and nobody answered the part that said about people with LIS and the deductible. The thing that is showing up as new for a lot of us is that pre-initial coverage period where their co-pays, even if they are full subsidy, their co-pays are higher until the deductible has been met, and then the co-pays go down to the full subsidy amount.

(Tracey Baker): This is (Tracy). I answered that questioner earlier. Like I said, it may be a specific case. I am not really sure. You know, you indicated that, you know, it is really based on what the person puts into the Plan Finder and I am hardly a Plan Finder expert.

(Terry Gandell): Yes, I was just clarifying that if somebody does have full subsidy, something that a lot of us were not familiar with before is when you look at the deductibles and you look at the chart month by month, until they meet their deductible, and all of our zero premium LIS plans have a deductible this year, they pay a higher co-pay than they would if they were - and then it goes back down to the full subsidy amount.

So it is whether you have full or partial, you could see a different amount.

(Tracey Baker): Okay.

(Terry Gandell): But that is new for a lot of us. We have not seen that before this year.

(Tracey Baker): All right. I have your contact information and (Christie) and I do need to talk to me about the reassignment letter anyway, so how about we talk to you, you know, offline and look at some specific examples that you are referring to.

(Terry Gandell): That is fine. It was not my question, I was just trying to clarify.

(Tracey Baker): Oh, okay.

(Terry Gandell): Thank you.

(Tracey Baker): All righty.

Woman: And if you do have questions...

Coordinator: (Dawn Crouse) you may ask your question.

(Dawn Crouse): Yes. I am already finding that there are violations of the regulations on contact. I have a client last week that received a phone call from a quote unquote call center. She was led to believe that it was Medicare calling and an appointment was set up for someone to come out.

And I was invited by a neighbor who knew what I was doing to sit in. And of course I did not identify what I do, which is Mississippi Senior Medicare Patrol.

So we had a little undercover thing going. And the agent violated - he told on an MA plan, he told the beneficiaries, which was her neighbor and the beneficiary that had an appointment that it was like a supplement except you do not have to pay for it up front.

So who is going to take these violations, especially when there is multiple violations about the phone calls begin with the misleading thing about Medicare that the person was representing Medicare, and the agent who did not correct explain the policy.

Woman: Oh, someone can do those?

Camille Brown: Hi, this is Camille Brown. You need to contact - if you have a regional office contact...

(Dawn Crouse): Yes.

Camille Brown: ...you need to contact that person and provide them with the information that you have on the complaint.

(Dawn Crouse): Okay. I - and I also, you know, I was just curious so I asked the guy, the agent, if that was the only plan. So he actually writes for three different plans, which is what we have all thought for the beginning.

They burn themselves out with one plan and then they just go to another one and start all over again.

Camille Brown: Right. I would just recommend that you contact your regional office so that they can conduct further investigation of the complaint.

(Dawn Crouse): Okay, thank you.

Coordinator: (Diana Mariklin) you may ask your question.

(Diana Mariklin): Thank you. This has come up two times already this year. And it has to do with Medicare that is basically retroactive. I had a number of patients to come in or have called our offices to set up an appointment to do a Part D enrollment, and saying that they have just gotten their notification that they qualify for Medicare.

But they have received their card, and the card has a retroactive date going back like six, seven months, sometimes longer than that. And so with regard to enrolling new Medicare members into a Part D plan, how do I make the determination when to - it is when they are actually able to roll into a Part D because they have just gotten it, but it was retroactive.

(Lynn Orlosky): Well I can start it out because I think Kay has a lot of experience with that. But basically what we have done is when - in our - per our policy for Part D eligibility, we say when there is a retroactive determination...

(Diana Mariklin): Um-hmm.

(Lynn Orlosky): ...eligibility for Part D begins the month that the individual received the notification of that decision. You know, we can sometimes - Medicare can actually go, you know, go back several months. So therefore Part D begins the month they received the notice, and then we actually say their eligibility continues for three additional months following that notice.

And Kay did you have anything to add because I know you have worked on some real cases in the system?

Kay Pokrzywa: I agree with what (Lynn) has said, and this is our policy that in essence, there is no retroactive Part D. For instance, in this case, if the individual receives their notification of entitlement to Parts A and B in November, do not assume that they are eligible for Part D prior to November.

That is basically how it works. There is no retroactive D when Part A and B are retroactive.

(Diana Mariklin): Okay. So, excuse me but I need to ask another question regarding this. So if someone, for example, gets like you said, gets a notice in November at they are eligible for a Part A and B, and they come in to my offices and say now I want to sign up for Part D.

They are eligible to sign up for Part D beginning that November, that month of November and three months after that which would take it into December, January, at the end of January or the beginning of February.

(Lynn Orlosky): Well I think if they got it in November, we say the month of the notice plus three months. It would be November, December, January and February.

(Diana Mariklin): Okay.

(Lynn Orlosky): So. Yes, and the plans actually have this so they should be aware of, you know, being able to accept this for this timeframe, and our system will accept it.

(Diana Mariklin): Okay.

(Lynn Orlosky): And the other half peak from - that Kay kind of alluded to as well as that. I think that you had mentioned that the effective date is going to generally be perspective. So it is going to be based upon that they enroll in a plan, it is going to be for the first of next month. So in November it would be for December 1, December January 1 etcetera.

(Diana Mariklin): Right. Okay so this, just to clarify a little bit more for myself, a patient that I had for example, came in in October saying that they had just gotten their notification that they qualified for A and B.

And they got, at the same time, they got their card that said the effective date of their Medicare A and B was July instead of October. But they - in October it was when they got the dates, and their notification.

So they would still be able to sign up for Part D from October through and then three months after that.

Kay Pokrzywa: Correct.

(Lynn Orlosky): Correct.

(Diana Mariklin): Okay. Okay. Because that - thank you very much. It has been a - I have not been able to find any information in the system with regard to that little peculiarity. So, I appreciate that.

Man: Before we go to the next question, could we go back to the previous question?

Susan Hollman: Sure.

Man: The question regarding the agent practices in Mississippi. In addition to reporting to the regional office, you should also report that information to the State Department of Insurance because they have the authority to go after the agent whereas we would go after the plan. So report it to both indices. Thank you.

Susan Hollman: Thank you. We are ready for the next question Operator.

Coordinator: (Belinda Jones) you may ask your question.

(Belinda Jones): Hi. If I am correct, there is somebody there an expert on marketing materials, is that correct?

Man: Yes.

Susan Hollman: Yes.

(Chevell Thomas): Yes.

(Belinda Jones): I have a flyer that is being passed around from a insurance agent from Medigap policy from the Medical Advantage off. And I just wondered, how

do we know if it has been approved? It looks like one that she has just done up herself.

It has got some generic information on it. Like more benefits for you, eyeglasses, hearing aids, dental benefits, and then it says, it has got a copy of a fake Medicare card. Choose your own doctor, choose your hospital, guaranteed issued life insurance policies to fit your budget.

Don't think you can get life insurance? Yes you can. And then it has got - she is licensed in Georgia, South Carolina, North Carolina, Virginia, Washington, Pennsylvania, Maryland. And it has got her name and it has got her phone number and email from the Medical Advantage Shop out of Savannah, and it has got her phone number.

But, and she is passing this out to seniors and leaving them in different locations in Savannah area. Is this something that I need to send in to see if it has been approved, or can you give me some guidance on this?

Man: If it is Medicare supplement, then I do not think there is anyone here that could answer that question. (Jim) would probably be the best person to send it to. And it sounds like this is a Medigap issue. If it were a Medicare Advantage plan there should be an approval number at the bottom of the advertisement, but it does not sound like it is a Medicare Advantage ad.

(Belinda Jones): Well Medicare Advantage might cover eyeglasses and hearing aids and dental benefits. So it could be.

Man: But if it does not identify a specific plan, it is hard to figure out what it is.

(Belinda Jones): No it does not identify a specific plan. It just kind of grabs your attention and then you call her and I guess that is when she goes over the policy with you.

Man: Yes. I thought you said it said something about Medicare supplements though.

(Belinda Jones): No it says, coming from the Medical Advantage shop is where she works out of. It is your health - your life and health advantage shop. It must be a shop that is set up out of Savannah, Georgia. And it has got the agent's name on here and her phone number email.

Woman: Internet (unintelligible) advantage.

(Belinda Jones): I don't have any kind of logos or any kind of approval codes or anything like this.

Woman: Okay.

Man: I would recommend that you send something like that to the State Department of Insurance for them to follow up on because there is no real link to a plan for us to go back and follow up with based on the information that you have.

(Belinda Jones): So I wouldn't send it over to the medic?

Man: I am not sure. I am not familiar with what the medics do.

(Belinda Jones): Well they kind of investigate the plans, but I wonder if they...

Woman: Well it does not have a specific plan on it, so...

(Belinda Jones): No.

Woman: ...we would advise you to send it to the Department of Insurance.

(Belinda Jones): Okay, thank you.

Coordinator: (Suzanne Ruff) you may ask your question.

(Suzanne Ruff): Hi. I have two questions actually. One of them I wanted to just go over that open enrollment period again for someone who enrolls in one plan and then enrolls in another. Don't they automatically get dis-enrolled from the other, from the first plan they enrolled in?

Woman: I mean generally, but if it is within the same enrollment period, so we are talking November 15 through December 31.

(Suzanne Ruff): Right.

Woman: If it is the same - this is the annual election period.

(Suzanne Ruff): Right.

Woman: So what we do within that timeframe is real - the latest basically application date during that enrollment period will basically trump.

(Suzanne Ruff): Okay, okay.

Woman: And if I can chime in, you are correct. The system will automatically dis-enroll the beneficiary from the plan with the earlier application date.

Woman: Correct.

Woman: So the beneficiary does not even have to talk to the other plan.

Woman: That is true, that is true.

(Suzanne Ruff): Okay. The other question is on the Plan Finder, how can I identify if a plan is using the reference based pricing? Are you familiar with that?

Woman: No. Again we do not have anyone here who is an expert on Plan Finder.

(Suzanne Ruff): Okay.

Woman: So if you could send that question into their mailbox?

(Suzanne Ruff): And what is the mailbox?

Woman: MPDPF_inquiries@cms.hhs.gov.

(Suzanne Ruff): Okay. Thank you.

Woman: Thank you.

Coordinator: (Charles Clarkson) you may ask your question.

(Charles Clarkson): Yes. This is a follow up on the previous question. We have had people who have changed their plans and enrolled into a new plan and obviously they are dis-enrolled from the first plan. But how many times can they do that? Is there a limit? Can I say oh I made a mistake after doing the research with us? Can they change plans again and again or is there a limit on how often that can occur?

Carol Eaton: They can change - it is an operational question. And we can process as many changes as they can manage to get the application to the plan.

Woman: But I think that - I mean Carol makes a good point, but I think that the more that there is in the system, increases the likelihood that there could be a mistake. Again, it will still recognize the person's latest, you know, application that is submitted. But, you know, if there are multiple, I mean multiple, multiple...

(Charles Clarkson): Right.

Woman: ...of this submitted, there might need to be some case work.

(Charles Clarkson): Okay, so if you - let us say you join a plan late and let us say sometime in the last week in December and you go to the drug store and they do not have you enrolled because not enough time has gone by to do all the entry of your name and stuff into the new plan.

So the point of sale, if you get to the drugstore and the drugstore guy says look, I do not have the information on your new plan, they are supposed to give you a 30-day supply. Is that still the rule?

Woman: If you are dual eligible or LIS.

Woman: Only if you are dual eligible or LIS, not just for any beneficiary…

((Crosstalk))

(Charles Clarkson): Oh really. So, if there are people...

Woman: Is (Frank) still on the line?

(Charles Clarkson): Excuse me?

Woman: (Unintelligible) he had to drop off (unintelligible).

Man: He had to drop off.

Woman: I think our drug coverage expert has actually dropped off. So I cannot - I think Debbie is correct for the duals. I am not sure about the others.

Woman: If you have not been an auto-enrolled in a plan already as a dual eligible or…

((Crosstalk))

(Charles Clarkson): Yes, I am not talking about dual eligible.

Woman: Yes, I mean…

(Charles Clarkson): If someone just waits till the last minute to change plans and gets to the drugstore, there is no longer a catch where they can basically bill a general plan and then make up for it later?

Woman: Well I think that ultimately if the person is enrolled in that plan, I mean, the everything will be made right eventually.

(Charles Clarkson): So they just need to keep the receipts and...

Woman: Yes. Yes.

(Charles Clarkson): ...but what happens if they need their prescription at that time?

Woman: Well from an operational standpoint what happens is, and we are going to say the beneficiary enrolls in the plan, the plans need to submit the policy set. The plans need to submit the enrollment to us within seven days. And that enrollment action to get through our system has to include the new 4RX information.

And generally speaking, the 4RX information goes to the system that the pharmacies look pretty much overnight in most cases. So generally, if the plan gets the enrollment transaction into us really fast, the next day or so, then it will be to the pharmacy very quickly. So the pharmacist should have that information.

(Charles Clarkson): Okay. But let us presume that something goes wrong and it is not done that quickly, and then can you still bring a letter with you saying you joined a new plan and you can look it up based on that or is that no longer applicable.

Woman: Well I think you can still bring your acknowledgement letter, but if you are enrolling towards the end of, you know, towards the end of the month, or, you know, December, you know, the plan has, you know, a couple days to actually get you that, you know, get the beneficiary that letter.

(Charles Clarkson): Right.

Woman: So it might be, the plan may still be within our timeframes to get the beneficiary the appropriate notice...

(Charles Clarkson): Yes.

Woman: ...but I mean if they have that notice, they certainly can take it because we do actually require the 4RX data…

((Crosstalk))

(Charles Clarkson): Right, and the only...

Woman: Right, we do.

((Crosstalk))

(Charles Clarkson): The only reason I ask this question is because I am doing some presentations unfortunately the week before Christmas. So I am afraid that once I give a lecture on changing plans and people decide they want to do that, it may be too late and then they are going to go to the pharmacy in January and there is going to be some sort of error because they did not do it quickly enough. And that is the only reason I was asking the question.

So I presumed that there was still some sort of backup emergency for anybody who when they get to the pharmacist, I do not have your records, I am not going to give you anything? Is that what you are saying?

Woman: Well, you know, I am a Federal employee. And if they do not have my insurance on the first of January, then they say save your receipt or I will give you a small amount and bill you for that until I get it from the insurance company. And I will...

(Charles Clarkson): Yes. But that would be optional then? It is not mandatory?

Man: No that is at the discretion of the pharmacist.

(Charles Clarkson): Okay.

Woman: Because ultimately the pharmacist might be left on the hook, so.

(Charles Clarkson): No I understand that but I - because I know, I thought early on we had some sort of backup whether you guys named a general plan that could always - if there was a problem they would bill that general plan and then it would be worked out later?

Woman: Yes. The only backup we have ever had to my knowledge is the point of sale facilitated enrollment. And again, that is only for dual eligibles and LIS.

(Charles Clarkson): Okay.

Woman: But if you want to learn more about that, which I do not - I think you said early on that that is not the population that you are concerned over, but...

(Charles Clarkson): No I am not, no, yes. Okay.

Woman: ...but if anyone else on this call wants to learn more about it, we have some reference material on our pharmacy Web page on the CMS pharmacy Web page that has like a tip sheet four steps document, a lot of reference materials on point of sale.

(Charles Clarkson): Okay thank you.

Coordinator: (Stef Friedland) you may ask your question.

(Stef Friedland): Hello. I was wondering if there was any effort to do an intelligent reassignment.

Woman: (Unintelligible) no - still?

Woman: What specifically are you referring to?

(Stef Friedland): Fair enough. I am sorry. I am a little green in this.

Woman: (Unintelligible).

(Stef Friedland): Just, I mean for to do low income subsidy, patients help them find plans, should drugs be dropped from their plans, and help them find ones where they do have appropriate coverage?

Woman: I mean I think you are...

Woman: Email.

Woman: I do not believe that there is an effort to look at it from their perspective. And (Christie) you probably want to jump in here, but I think their reassignment is focused primarily on enrollment and cost from, you know, a premium sort of cost perspective than it is, you know, coverage, a coverage perspective.

((Crosstalk))

Woman: And they know (unintelligible) that.

Woman: (Unintelligible) that that is what you are getting at.

Woman: Yes, but outside (unintelligible) certainly propose that idea, but from our perspective we purchase more random, it is randomly (assigned) that, you know, aside from trying to keep people within the same organization. So at this point, the answer is no. But it is a tricky question.

Man: I think one thing to note also is that given the formulary review that CMS does to ensure that every plan has at least two drugs in every drug class, if we have to do this at a class level, it would not matter because all plans would be able to cover any beneficiary. They may not have the specific drug that that beneficiary is taking, but they would have a therapeutic alternative that that beneficiary could take in place.

(Stef Friedland): Oh, okay. And can I just ask a quick follow up? Is there any thinking that - is there any anticipation on this (intelligent) (unintelligible) might come about under a new administration?

((Crosstalk))

(Stef Friedland): Boy I am asking the funny questions aren't I? All right.

Woman: Well I think it is a fair question.

Woman: Yes.

Woman: I think that has been considered. I think for the, you know, the folks that are at this table, I mean it is not something we do not think is necessarily a bad idea or, you know, way on one side or the other, but it is just something that, you know, the decision as (Christie) made is, you know, basically to choose the random assignments.

Woman: Yes, there are one or two (FTOPs) who, yes...

Woman: (Unintelligible).

Woman: ...who know their population's needs well - who seem to know their needs well. And you may - I do not remember which ones they are at this point. I am not sure.

Woman: I believe Maine actually tried to use a certain algorithm and (unintelligible).

Woman: Yes. And you may want to look - contact, you know, we think it is the main (FTOP) but you may want to contact them and find out how that has worked for them and do a little...

(Stef Friedland): Um-hmm.

Woman: ...research, you know.

(Stef Friedland): Sure.

Woman: But, you know, they had to work within the (FTOP) guidelines, you know, there are qualified (FTOP) guidelines on our Web site. So, the processes still remains fair to the plan.

(Stef Friedland): Right. Okay, thanks very much.

Coordinator: (Matthew Shotkin) you may ask your question.

(Matthew Shotkin): Thank you. I am wondering, I had sent you an email this morning saying what is the general amount of the Medicare trust fund because I asked that

question during a forum and Hunter on November 24th and it was never answered. The panelist sort of ducked the actual question.

Woman: Let him repeat it.

Man: I am sorry, could you repeat it please.

Woman: I heard him. I heard your question. He - we had a question (unintelligible).

(Matthew Shotkin): I was asking what is the general amount of the Medicare trust fund? I asked the question during a forum at Hunter College in New York back on November 24th and it was never answered. The panelists sort of ducked the question or did not want to answer it.

Woman: You want to?

Man: Yes. That information is publicly available and should be in the CMS Trustee's Report. I believe you could just do a Google search for, you know, Medicare Trustee's Report in a given year. You should be able to find that pretty easily. And if not...

(Matthew Shotkin): So in other words, if I go to Google and do Medicare Trustee's Report I will find it?

Man: You should. And if you cannot, go ahead and punch an email to...

Woman: Well the other place you can find on the Internet is the Annual Chief Financial Officer's Report. And that has our accounts that are public information. Every year that is published. The new one will be published December for fiscal year 2008.

(Matthew Shotkin): So that was the Annual Chief Financial Officer's...

Woman: Report.

(Matthew Shotkin): ...Report.

Woman: Um-hmm.

(Matthew Shotkin): Thank you.

Coordinator: (Barbie Richardson) you may ask your question.

(Barbie Richardson): Yes. I had a gentleman in my office this morning that had lost his full dual status as of middle of November. How soon will the Plan Finder actually be available to show the new updated information for him because I tried to run the information today and it was still showing the special needs plans like for Pennsylvania, the (Unison) the Gateway that type of situation which he will no longer be available for.

Woman: Again that is another Plan Finder question that we are not able to answer at this time. If you could send your question into their mailbox, the mpdpf_inquiries@cms.hhs.gov, they would be able to respond to you.

(Barbie Richardson): Okay.

Woman: Bye.

Woman: Can you - yes.

Woman: Let me just respond. If a person loses their dual status in November, they are still going to be deemed for all of the following year. And their co-pay level for instance will not change. I mean it will not get worse as it were.

Woman: Um-hmm.

Woman: So in that particular situation, that person would still be deemed through 12/31/2009.

Woman: Right.

Woman: But they may no longer be dual eligible from Medicaid, you know, FSA (unintelligible).

Woman: Correct.

Woman: But they are from Medicare's point of view (unintelligible)

((Crosstalk))

Woman: (Unintelligible) for our, for...

Woman: Which means they retain their low income subsidy at the same level through the end of 2009.

Woman: I see. Cannot belong to - can they still belong to the special needs plan (unintelligible)?

Woman: No. And I think that that is a separate, that is a separate issue. They are eligibility for a dual special needs or a special needs plan that serves dual eligible individuals. It is separate and aside from the low income subsidy...

Woman: Correct.

Woman: Right.

Woman: ...that they would be eligible for in Part C.

Woman: Correct.

Woman: So, I think that that is what the caller is asking. There is a dual status flag that is showing on the Plan Finder that might be separate from the LIS. Is that correct?

Woman: I think she may have already.

(Barbie Richardson): I am still here.

((Crosstalk))

Woman: Oh.

Man: Oh you are here? Okay.

Woman: Good.

Woman: Is that - there was not so much just for the purposes of LIS, with the low income subsidy, it is for purposes just showing as a dual eligible.

(Barbie Richardson): Basically, yes, I was looking to find out when that flag comes off because he is no longer a full dual.

Woman: And that would be something for the, you know, the Plan Finder team.

(Barbie Richardson): Plan Finder. Okay.

Woman: Do we have a next question?

Coordinator: (Sally Rice) you may ask your question.

(Sally Rice): Yes thank you. Good afternoon. I work with dialysis patients and my question is really trying to figure out how to coordinate Part D with their eligibility for Medicare. They become eligible generally for Medicare three months after they start dialysis.

And usually what I am told is they cannot even apply for the Part D until after that date which often then means it is like two months before their Part D becomes available. Any hints on how to better coordinate that?

Woman: I think what you are saying is that from the dialysis, they - regards to whether they self dialyze, that their Part D eligibility date do not appear to be coordinating? I mean...

(Sally Rice): Well no, it is - I am not talking about self-dialysis because that starts immediately.

Woman: Right. Right.

(Sally Rice): But for the in - those who are dialyzing in center, they will go down and apply. They will get a thing saying that on such and such a date you will be eligible. And that does not seem to be enough to go ahead and enroll them in Part D so that it begins at the same time as their A&D.

Woman: Well, I mean, it should. So I am not exactly sure if there is...

(Sally Rice): Okay.

Woman: ...if there is some type of an issue surrounding that because we do have - I mean from the Medicare Advantage line, there is the, you know, the initial enrollment period that surrounds, you know, becoming eligible for Medicare, even if it is based upon disability.

And then the same thing on the Part D side where we basically have an initial enrollment period for Part D.

(Sally Rice): Um-hmm.

Woman: So, they have specific cases that you are having issues. I mean, I would like you to submit them to (Eric).

(Sally Rice): Okay.

Woman: If there is - but if there is anything that is unclear, you know, maybe the plans are misunderstanding our guidance, you know, we can certainly like clarify if there is anything that is, you know...

(Sally Rice): So they should...

Woman: (Unintelligible).

Woman: ...if we have missed something.

(Sally Rice): So I should be able to help them coordinate so that the same month that their A&B become effective, their D becomes effective.

Woman: You could, yes, yes.

(Sally Rice): That should be the way it would work.

Woman: Yes.

(Sally Rice): Okay.

Woman: But it just - for the individual to, I mean again, or separately aside - I mean we do see folks with a ESRD when there is a - if there is a retro determination?

(Sally Rice): Um-hmm, um-hmm.

Woman: And now we come back to what we talked about earlier...

(Sally Rice): Right.

Woman: ...on the call where you get the notice, the retroactive is determined, but then it is based upon when you get the notice and then you get three months after that. So...

(Sally Rice): Right.

Woman: ...I mean it should be falling into one of these two buckets. If it is falling outside of that, I would be interested. There might be some misunderstandings at the plant.

(Sally Rice): Okay. Thank you.

Woman: If you can send some examples because it may have to do simply with the time lag from when Social Security actually sends us their Medicare entitlement.

(Sally Rice): Well, okay. Based on one started today on dialysis.

Woman: Um-hmm.

(Sally Rice): It would give them - we would give them their 27, 28 say within a couple weeks for them to go to Social Security and apply for Medicare. So say by January 1 they would have applied. And it should be effective March 1 with December, January and February being their waiting months.

And usually, I - they cannot do anything about their D. I will advise them to apply for A, B & D, and then they - and it never happens. And we try to find out and I said well they never enrolled. So it almost...

Woman: If you could...

(Sally Rice): And now the other one does happen what you were saying with the retroactive, yes, I have a horrible coordination time with someone who was on SSI, then gets disability retro or something and they are dropped from the SSI and then it takes - they are not automatically put back on a D plan. That is a whole nother issue.

But, you know, it just seems that the application for D is not taken because it does not show that they have A or B yet.

Woman: Actually, I mean it would be really helpful if you could actually send some of these specific case examples.

(Sally Rice): Okay.

Woman: And then Debra what I would like to do with my team is like look at our guidance...

(Sally Rice): Um-hmm.

Woman: ...and if we need to clarify any of the, you know, our enrollment period information from the plan, you know, that would be helpful.

(Sally Rice): Thank you.

Man: If you could drop a note to our mailbox, it is nmtp, that is Nancy, Mary, Tom Paul and cms.hhs.gov.

(Sally Rice): Okay, I sure will.

Man: Thank you.

(Sally Rice): Thank you.

Woman: Thank you.

Coordinator: (Jennifer Radcliffe) you may ask your question. (Jennifer Radcliffe) check your mute button. Your line is open.

(Jennifer Radcliffe): Hello?

Coordinator: Your line is open.

(Jennifer Radcliffe): Hi can you hear me?

Man: We can hear you.

(Jennifer Radcliffe): Okay thanks. Sorry about that. I wanted to ask about the penalty. I still have people who even though Medicare D has been around for a few years now, they never did enroll, they did not have principal coverage, and now several years into it, they want to think about enrolling because now they are on medicine for whatever reason.

And I was wondering if you have a dollar and cent amount of your - of what the penalty would be added on to their premium?

Woman: It is 1% of the, you know, National Benchmark amount. I am not exactly sure what that is for this year. We are developing a tip sheet, actually updating the tip sheet for this year. I know that late enrollment penalty is in our area. So we can certainly, you know, it should be, and I am sure it might be on the Web site. I just do not know it off the top of my head.

So, I mean, whether it is going to be a couple dollars or, you know, I do not want to give like a wrong amount, but it generally is like 1% of whatever the (stench) mark amount is. So, I mean if anyone else knows...

Man: (Stenchmark) for ’09 is approximately $28.

Woman: Yes. So it should be approximately like $2.80 per month per uncovered month.

(Jennifer Radcliffe): $2.80 per uncovered month.

Woman: (Unintelligible).

Woman: One percent.

Woman: No one - it is 1%.

Man: One percent per uncovered month.

Woman: Right, for uncovered month.

(Jennifer Radcliffe): Twenty...

Woman: Twenty-eight cents.

Woman: Twenty-eight cents.

(Jennifer Radcliffe): Oh 28 cents per uncovered month.

Woman: Right.

(Jennifer Radcliffe): So.

Woman: (Unintelligible) desk.

(Jennifer Radcliffe): Okay. So for now into a few years of it it will be you said maybe around $28.

Woman: It could, I mean, I do not know what the - I mean I do not think now for a couple years it could - again it is going to be for the number of uncovered months. So it is going to be that amount times the number of uncovered months. So it could be a couple dollars, you know, additionally per month.

(Jennifer Radcliffe): Okay.

Woman: But it is conceivable that you could be getting $5, $6, $7 extra premium per month.

(Jennifer Radcliffe): Okay. Okay thanks, that helps.

Coordinator: (Theresa Aldridge) you may ask your question.

(Theresa Aldridge): Hello? Hello?

Man: Go ahead.

(Theresa Aldridge): Hello?

Woman: We can hear you.

(Theresa Aldridge): Oh okay. I am also dialysis social worker. I have an ESRD patient who is enrolled in a Medicare Advantage plan right now. Is she, is he able to enroll in another Medicare Advantage plan during this open enrollment? But here is the

caveat to that. His wife, who is currently working, has an HMO plan which he is covered under, will be due to retire in July of next year.

And the plan - the type of plan that they are proposing to the wife and her spouse is another Medicare Advantage plan.

Woman: Yes. I mean generally our - there is a general prohibition against individuals with end stage renal disease enrolling in a Medicare Advantage plan. We have, you know, developed several exceptions.

In this case, the really the only option, if this person is already in a Medicare Advantage Plan...

(Theresa Aldridge): Um-hmm.

Woman: ...would be another plan offered by the same organizations. It is pretty limited. I mean there is a couple other exceptions, but it is, you know, without knowing the details of this case, you know, you might ask the, you know, I mean, the individual could possibly work with, you know, one of the individuals with health plan to see if they have something else that might be offered.

But, you know, generally employers are going to offer something different than possibly what is offered to the general Medicare population. So it is unlikely that this individual will have other opportunities.

And if he does decide to dis-enroll from the Medicare Advantage plan, it is unlikely that he will ever, you know, unless the law changes to allow for enrollment, to enroll, you know, in another...

Woman: (Unintelligible).

Woman: ...Medicare Advantage plan. So I would just kind of proceed cautiously and maybe check to see what other options, you know, might be available from that organization, but it is probably unlikely.

(Theresa Aldridge): So even when she does retire, the option of having that Medicare Advantage through her retirement for her husband who is the ESRD patient may not be like...

Woman: Well there are some, I mean, there are some exceptions for employers. But again, without knowing the specifics, you know, possibly a CMS case worker might be able to assist you like where, you know, where your health plan, or where that beneficiary is living.

(Theresa Aldridge): Okay (unintelligible).

Woman: But a lot of these get very case specific. And so I do not want to just, you know, provide some general...

(Theresa Aldridge): Ah, got it. All right. Thank you.

Woman: Sure.

Coordinator: (Janice Quintenas) your line is open.

(Janice Quintenas): Yes, I have a question. I work for a Medicare Advantage program for end stage renal disease patients and we have run across an issue several times where their Part B coverage is actually included in their Medicare package.

And their Part D is not - does not cross over. We do not administer their Part D under our MA plan. So if Part D confined to the same enrollment period as annual open enrollment, if it is included in there as Medicare policy?

Woman: Well I think you are talking about whether or not they have been a member of the commercial health plan, right? And now...

(Janice Quintenas): They previously, to qualify they have to be enrolled in traditional Medicare. And a handful of our members had their Part D drug plan with Medicare versus another commercial Part D drug plan. And sometimes we do not find out until after the fact. So are they held to the same enrollment period as...

Woman: Oh for Part D.

(Janice Quintenas): Right. Or can they change that Part D drug plan at any time?

Woman: No. I mean, there is not a special enrollment for Part D for individuals with end stage renal disease.

Woman: So generally they are, you know, limited unless they meet one of the, you know, other exceptions listed in our guidance. You know, generally, they would be limited to making changes during this November through December period.

(Janice Quintenas): Okay. So if we find out after March 30, because sometimes there is a lag in it once they do the billing, and find out, you know, Medicare has given a denial stating, you know, they do not have Medicare anymore?

So they have missed that opportunity. Are they just out of luck as far as having a Part D drug coverage until annual open enrollment again?

Woman: I mean, I mean it does not sound, I mean if they, and so, I mean generally individuals need to make a choice by December 31st. So, you know, I mean, that it, I mean, that is pretty much the cutoff.

And that is not something that we established. That was established by the law. So, I mean unless there is a, you know, exceptional circumstance here, I mean, no, an individual would be without coverage.

But I guess I am not sure that I am following about the, you know, you are not getting information about the billing until March 30. So...

(Janice Quintenas): Well a lot of our members are very sick, having kidney failure. And so there is not of clarity and they are handling stuff that maybe they shouldn't be, but we are not aware of that until after the fact. So then they are calling, you know, with issues stating the pharmacy is not going to cover it because Medicare denied it.

We check into it and find that, you know, indeed their Part D was through Medicare. So we try to get them signed up with another Part D drug plan so that they are not having to pay...

Woman: (Unintelligible).

Woman: ...you know, for everything out of pocket.

Woman: Well from an operational standpoint, you said in fact you are a special need ESRD plan sanctioned by Medicare.

(Janice Quintenas): Correct.

Woman: With a contract with us.

(Janice Quintenas): Correct.

Woman: Well, okay, what you can do is you can - if you have a concern, you can run a BEQ and that will tell you not what Part D plan they have but it will tell you if their drugs are covered. So you have some ways of being able to check...

Woman: And I think that the other aspects of that - I mean if you are talking about a person who is in fee for service and it is a special needs plan and the individuals want to enroll in the special needs plans, I mean, there are - there is an SEP for the special needs plan, but just for the general Part D - if they wanted to, I mean, is that kind of the crux of your question is just, you know, they are coming from fee for service for Part D and now they want to enroll in your special needs plan. And you actually offer enrollment to ESRD individuals?

(Janice Quintenas): Yes. They have to be ESRD.

Woman: Okay.

(Janice Quintenas): And we are private fee for service.

Woman: Yes. I mean I think then I would, you know, from the plan perspective, you know, you need to follow the, you know, the rules obviously set down for, you know, that we have established for, you know, verifying that they have

that condition and, you know, we have established, you know, special enrollment period for, you know, special needs plans in our guidance.

So I think you can follow that, but outside of that and making changes, you know, than what we have in our guidance, I think that that should meet your question. So if not, I would actually just connect with your account manager if we have not, you know, if I have not understood your question and we can clarify through that, you know, that way.

(Janice Quintenas): Okay, thank you.

Susan Hollman: Operator we will take one last question.

Coordinator: (Sheila Gerber) you may ask your question.

(Sheila Gerber): Hi this is (Sheila Gerber). I am with Illinois' ADAPT. And I am having trouble actually receiving the notification of these meetings, these national Medicare training programs.

I have contacted the subscriptions.cms.hhs.gov. I am currently receiving them from my boss, (Nancy Abraham) who will be retiring December 31st so it is imperative that I get on the mailing list. Is there any way I can get on there?

Man: If you go to the CMS dot gov Web site, www.cms.gov, and you click over to Outreach and Education, and under that you will see Medicare, National Medicare Training Program.

And when you get onto that National Medicare Training Program page, if you scroll down to about the middle, you will see a link that you can click that enables you to register for that list there.

(Sheila Gerber): Great. Thank you very much.

Susan Hollman: Okay we have a clarification that we want to make before we end the call.

Woman: (Unintelligible) I just wanted to make one clarification with the ESRD piece about the employer group, you know, question, I think two questions or a couple questions ago.

There, you know, there is an option for Medicare Advantage organizations to utilize a waiver for their employer group or union sponsors.

Woman: Yes.

Woman: But again, that is at the option of the organizations, and they have to apply consistently. So, you know, for the person who had asked that question about whether or not the, you know, the husband would be able to, they may be able to, but then again, you know, that is at the option of the organizations offering that, you know, working with the employers.

And we encourage the organizations to work with their employers, but yet we cannot force them to actually implement that waiver. So, again that might be an option, but they would have to, you know, check with the MA organization to see what options would be available.

Susan Hollman: Okay. Thank you. I want to thank you all for participating in this audio call. The next call for training will be in January. If you have any specific topics that you would like covered, please submit them to our mailbox at nmtp@cms.hhs.gov, and from CMS to our valued partners, happy holidays.

END