

**[Slide #1] Medicare –How It’s Changing to Help More People:
A Teleconference Series for Health Care Professionals
*Helping to Fill the Coverage Gap***

**January 17, 2006
Noon EST**

Dolph Chianchiano: Hello and Happy New Year everyone. My name is Dolph Chianchiano. I am the Senior Vice President of Health Policy and Research for the National Kidney Foundation.

[Slide #2] The Kidney Medicare Drug Awareness and Education Initiative was established to inform professionals and people with kidney disease about Medicare Prescription Drug Coverage.

[Slide #3] Over 35 organizations representing patients, professionals of all disciplines, government and industry have participated in it. We’re glad you joined us today.

I’d like to welcome you to the final scheduled teleconference of this initiative. The series is entitled “Medicare—How It’s Changing to Help More People.”

[Slide #4] Our August teleconference described the changes to Medicare and “extra help” for those with limited income and resources. Our September teleconference addressed coordination of Medicare Prescription Drug Coverage with other drug coverage. Our October teleconference shared tips to choose a plan. Our November teleconference discussed formularies, exceptions, and coverage determinations. Our December teleconference covered appeals and grievances. Today’s teleconference will address resources to help patients with Medicare Part D cost shares.

You can find the transcripts and slides on www.kidneydrugcoverage.org. Click on teleconferences. Look for the *teleconference archive*. You can download and print the slides and the transcript. If your computer has speakers look for *Presentation*. You can watch the slides and hear the speakers at the same time.

[Slide #5] Our goal is to help people with kidney disease and kidney failure make the best decision about whether they need a Medicare drug plan and if so, which plan will help them afford to take the drugs they need to live long, healthy, and enriched lives. We know this is what you want too. This teleconference series is one of the many ways the Kidney Medicare Drugs Awareness and Education Initiative is working to meet that goal.

I’d like to introduce you to our moderator, Sandie Dean, who is the corporate social worker for Fresenius Medical Care of North America. Sandie will introduce our other speakers.

Sandie Dean: **[Slide #6]** Thank you for inviting me here today to moderate this teleconference on helping to fill the coverage gap. With me today are Janet Miller and Marge Watchorn of the Centers for Medicare and Medicaid Services; John O'Brien from the Pharmaceutical Research and Manufacturers of America; Phylis Ermann from the American Kidney Fund; and Bob Whitlock from the Missouri Kidney Program. If you are on this call, would you please let the operator know?

[Slide #7] Although Medicare prescription drug plans may vary, each plan must offer at a minimum, a standard level of coverage. Except for those with limited income and resources, plan numbers with standard coverage in 2006 will pay a monthly premium of about \$32.20 and a yearly deductible of \$250. After they pay the \$250 yearly deductible, here's how the costs work.

1. They will pay a 25% coinsurance of drug cost from \$250 to \$2,250.
2. Then, they'll have a gap in coverage where they pay 100% of the next \$2,850 in drug cost.
3. Then they'll pay 5% of drug cost or a small co-payment for the rest of 2006 after they have spent \$3,600 out of pocket. Their plan pays the rest.

[Slide #8] Medicare beneficiaries may join an enhanced plan that covers more drugs during the coverage gap and or covers Medicare Part D excluded drugs. These plans usually cost more.

[Slide #9] Those who have limited income and resources may qualify for extra help paying prescription drug costs. The amount of help they get is based on their income and resources. In May and June of last year, Medicare mailed letters to people who automatically qualified for this help—those with Medicare and full Medicaid, a Medicare Savings Program or SSI without Medicaid.

The Social Security Administration sent applications to some people who did not automatically qualify, but who had limited Social Security or Railroad Retirement income. If your patients received this application, encourage them to fill it out and send it back to the Social Security Administration. If they didn't get one, but think they may qualify, have them call Social Security at 1-800-772-1213. They can visit the Social Security Web site or apply at a state Medicaid office.

Except for drugs covered by Part A or Part B, Medicaid drug coverage was transferred to Medicare on January 1. Janet, what can you tell us about how CMS is transitioning dual eligibles into Medicare Part D?

Janet Miller: **[Slide #10]** Good morning and thank you for inviting me to be here today. Well, we have been busy. In the last month and a half of 2005, over 6 million dual-eligibles were enrolled in Medicare drug plans. And early 2006 data show about 1 million prescriptions per day are being filled. Plans have been working very hard to process enrollments as quickly as possible. This is important because as plans

process enrollments, the eligibility program used by pharmacists and a Medicare Drug Plan Finder on www.medicare.gov are updated.

[Slide #11] These tools and a customer service representative—they're called CSRs—at 1-800-MEDICARE can report to a beneficiary the plan, other drug coverage and extra help status. If someone other than the beneficiary calls, a CSR may release the name of the plan in which a beneficiary is enrolled as long as the caller provides the beneficiary's last name, date of birth, Medicare number, effective dates of Part A and B, and their zip code. By the way, these data elements are used to access the beneficiary information in Medicare Drug Plan Finder at www.medicare.gov.

You should also note CSRs may not disclose any additional information to any caller without the beneficiary's written or verbal authorization or some means for the CSR to verify in the system that the caller is the beneficiary's personal representative.

[Slide #12] However, during this transition period, in the case of a medical emergency, if a pharmacist needs additional information to fill a prescription, he or she should call 1-800-MEDICARE and let the CSR know about the medical emergency. The CSR will refer the case to special regional office staff to get the necessary information that will let the person get their prescription as soon as possible.

[Slide #13] CMS recognized that some people might not get their enrollment letters and ID cards timely, but wanted to make sure beneficiaries could get needed drugs without a plan ID. So, CMS contracted with two companies, one to validate dual-eligibility and enrollment status, and the other, called WellPoint, to accept claims and enroll dual eligibles who were not enrolled in a plan into Wellpoint's plan. Keep in mind beneficiaries with Medicare and full Medicaid can change plans later with their new plan taking effect the next month.

[Slide #14] So, if you have patients who need drugs now, tell them that when they go to their pharmacy that they need to take, 1) their Medicare card, or other proof of Medicare and that could be maybe an explanation of benefits; 2) any cards they have used to pay for drugs like a Medicaid ID card, and 3) they should take a picture ID.

[Slide #15] Pharmacists have three ways to run a check for eligibility and extra help status and this is done 24/7.

- The first is by computer
- The second is by calling 1-800-MEDICARE, and
- The third is to call a dedicated pharmacy help line set up specifically for pharmacist for—I'm sorry—for pharmacists. CMS has increased the staffing on this help line from 150 to 4,500 CSRs. This increase will help handle the additional volume and should also reduce pharmacist wait time. By using this

help line, pharmacists can determine plan enrollment status, as well as whether the beneficiary is eligible for low income subsidy co-pays.

[Slide #16] And something that you might need to know is that we have set-up additional processes to assure that dual-eligible Hurricane Katrina evacuees can use Medicare prescription drug coverage anywhere. They're simply flagged as Katrina evacuees in the Medicare beneficiary database. The evacuee can show the pharmacist wherever they are a Medicare or Medicaid card if they happen to have them or give the pharmacist identifying information such as name, Medicare number, date of birth, and show a picture ID. Those who are auto-enrolled in a national plan will be able to get drugs from a network pharmacy in any state. Those who were auto-enrolled in a regional plan in another state or area can go to a drugstore where they are now. The pharmacist can enter their information into a computer and the plan should pay the claim. The plan and pharmacist can negotiate to make the pharmacy where the beneficiary now is a network provider so the beneficiary can get drugs there for the time being. The beneficiary should only have to pay the \$1 or \$3 co-payment for covered drugs and should get a one time fill of a non-covered drug.

Sandie Dean: What is CMS doing to reduce gaps in coverage for those new to Medicaid or Medicare?

Janet Miller: **[Slide #17]** Well, CMS is going to auto-enroll those who become eligible for Medicaid into a Medicare drug plan if they don't already have one. And in a like fashion, CMS is going to auto-enroll in a plan those people with full Medicaid who're expected to get Medicare soon. CMS is going to do this before their Medicaid drug coverage ends.

Sandie Dean: What if Medicare beneficiaries are enrolled in plans that don't cover their drugs?

Janet Miller: **[Slide #18]** Well, they have a few options.

- The first is they can ask the doctor if there is another covered drug under the plan that would work as well.
- They can file an exception request with medical justification to get the drugs the doctor prescribed. And bear in mind, plans must respond to the exception request in 72 hours or 24 hours if the doctor requests expedited determination.
- And remember those dual eligibles can switch plans monthly to one that covers their drugs.

It is really important that you remember that all plans—all plans—should provide a first fill prescription at network pharmacies for dual eligibles that are enrolled in a plan even if the drug isn't covered. CMS wants to give them—them being the beneficiary—time to talk with their doctors about other covered drugs, to file an exception, or to switch to a different Medicaid—I'm sorry—Medicare drug plan. And also plans may extend the length of time to fill these first fill prescriptions.

Sandie Dean: What kind of transition process is there for those living in long-term care?

Janet Miller: [Slide #19] Well, Medicare drug plans will fill prescriptions at network pharmacies for non-covered drugs for at least 30 days and sometimes longer for people who are living in long-term care facilities. Dual eligibles living in a long-term care facility should have no co-pays for covered drugs and our—actually our preliminary reports on this are showing that they are getting prescription drugs with minimal problems.

Sandie Dean: Janet, what about anyone who is not dual-eligible who may have joined a plan late in December and didn't get information yet about what pharmacy is in network?

Janet Miller: [Slide #20] Well, a pharmacist can use the eligibility database that we have set up to find out what plan the beneficiary has. If that particular pharmacy where the beneficiary is standing is not in network for the beneficiary's plan, then the pharmacist has to give him or her information on how to contact that plan about its network pharmacies. Now, to avoid having to pay full price and wait for reimbursement from their plan, the Medicare beneficiary should go to a pharmacy in the plan's network.

Sandie Dean: [Slide #21] Marge, the Medicare Modernization Act excluded some drugs from coverage under Part D, such as drugs used for anorexia, weight loss or weight gain, fertility drugs, drugs for cosmetic purposes like hair growth, drugs used for symptoms of cough and colds, vitamins and minerals with the exception of vitamin D analogs which CMS considers a hormone, prenatal vitamins and fluoride, over-the-counter medications, benzodiazepines, and barbiturates. If someone has Medicare and full Medicaid, will Medicaid cover these drugs?

Marge Watchorn: [Slide #22] If the state covers one of these excluded drugs for Medicaid recipients who don't have Medicare in their state, then the state must also cover that drug for people with Medicare. Because these drugs are excluded from Medicare coverage, states will receive federal matching funds from CMS at the same rate they do for all other Medicaid drugs.

You can read more about Medicaid coverage of excluded drugs by state on our Web site at www.cms.hhs.gov/States/EDC/list.asp. If you click on the name of the state, it will link you to a one-page summary of which excluded drugs are covered by that state for categorically needy, medically needy, or both. If the form says "all," it means all drugs within that particular category are covered by that Medicaid agency in that state. If the form says "none," then Medicaid doesn't cover drugs in that particular category. If it says "some," we've provided a list of the drugs that Medicaid covers within that category.

Sandie Dean: Marge, what states offer help to elderly or disabled people through State Pharmaceutical Assistance Programs?

Marge Watchorn: [Slide #23] As of January 1, there were 36 qualified State Pharmaceutical Assistance Programs or SPAPs in 26 states around the country. A few SPAPs have not yet applied to CMS for what we call qualified SPAP status. The states that do have qualified SPAPs include Alaska, California, Connecticut, Delaware, Florida, Illinois, Indiana, Massachusetts, Maine, Maryland, Missouri, Montana, North Carolina, New Jersey, Nevada, New York, Rhode Island, South Carolina, Texas, the US Virgin Islands, Vermont, Washington, Wisconsin, and Wyoming. Michigan and Minnesota have informed us that they're planning to terminate their programs as of January 1 and Wyoming is terminating its programs for members who have Medicare on May 31 of this year.

Sandie Dean: How can SPAPs help those that have Medicare drug plan?

Marge Watchorn: [Slide #24] Well the Medicare Modernization Act which brought in the Medicare Part D benefit allows these programs—these SPAPs—to offer wrap-around benefits or help to fill the gaps in Medicare drug coverage. With Medicare's new benefit, the qualified SPAPs will be able to offer the same or better coverage and the beneficiary should end up paying less. If an SPAP member has a Medicare drug plan, the pharmacist would bill the Medicare drug plan first. If the SPAP offers wrap-around coverage, then the pharmacist will bill the SPAP as a secondary payer. Whatever payments the qualified SPAP makes will count toward the member's true out of pocket costs or TrOOP. This helps the Medicare plan member who gets help from a qualified SPAP reach Medicare's catastrophic benefit faster. Qualified SPAPs can require that the plans it coordinates with offer the SPAP's formulary drugs.

Sandie Dean: Why is help from some SPAPs not counted toward TrOOP?

Marge Watchorn: [Slide #25] The MMA was intended to promote competition among plans and to ensure that Medicare beneficiaries have freedom of choice of plans. If an SPAP steers its member into a specific plan and only offers help to people who are in that plan, then CMS would consider that SPAP to be non-qualified. Any help for Medicare drug costs that the beneficiary would receive from a non-qualified SPAP would help that person at the time, but those SPAP payments would not count toward TrOOP and would not help that person reach the catastrophic benefit sooner. However, it's important to note that at the current time, none of the SPAPs that we're aware of are steering their beneficiaries into a specific plan. So right now, there are no non-qualified SPAPs.

Sandie Dean: How can benefit - Medicare beneficiaries learn about what these programs offer?

Marge Watchorn: [Slide #26] The MMA provided grants in the amount of \$125 million over a period of two years to SPAPs to educate their enrollees about the new Medicare prescription drug coverage. CMS awarded these grants to 21 states. SPAPs can use these funds to offer telephone or in-person counseling to help Medicare beneficiaries enroll in plans, as well as providing assistance through other

outreach activities. Your listeners can read more about SPAPs on the CMS Web site at www.cms.hhs.gov/States/07_SPAPs.asp.

Sandie Dean: Beth Witten is filling in for Bob Whitlock today. Beth, what can you tell us about the Missouri Kidney Program and Part D?

Beth Witten: [Slide #27] Well, Missouri Kidney Program, or MOKP as we call it, is state-funded and is housed within the School of Medicine at the University of Missouri Columbia. In 1968, MOKP was established with \$100,000. Today, the budget is around \$4 million.

Missouri Kidney Program provides several benefits to eligible Missouri dialysis and transplant patients in addition to providing formulary drugs through a mail order centralized drug program. MOKP also pays spend downs for MKOP patients so they have continuous Medicaid coverage.

MOKP is working closely with Missouri Rx, which is the qualified SPAP in Missouri, and Missouri Medicaid on Medicare Part D. Missouri Medicaid will pay for certain benzodiazepines and barbiturates, some vitamins and minerals, some medicines for colds and coughs, some of the over-the-counter drugs for dual-eligibles. Missouri Rx will pay half the Part D co-pays for Missouri dual-eligibles and, as budget allows, MOKP is going to be paying the other half of the co-pay for dual-eligibles who received MOKP help. We've also learned that four state kidney programs are qualified SPAPs. These are Delaware, Maryland, Texas, and Wisconsin.

Sandie Dean: I understand that pharmaceutical manufacturers have been giving free drugs away to low income individuals for years and now that the Medicare drug benefit is in place, this maybe changing. Is that true, John?

John O'Brien: [Slide #28] Well, for many years pharmaceutical companies' patient assistance programs or PAPs, have helped create a safety net by providing needed medicines to low-income individuals who didn't have prescription drug insurance. And in 2004 these programs filled an estimated 22 million prescriptions for about several million people including both Medicare beneficiaries and individuals not eligible for Medicare. Now, each PAP is structured in a different way. A common approach is to provide drugs at no or very low cost.

[Slide #29] So recognizing that medicines are playing an increasing important role in good health, insurance is the key to good access to needed care. So the pharmaceutical industry believes that America's seniors will benefit from a successful Medicare drug insurance program. And now that it's in place, Medicare beneficiaries have a private sector insurance option that they didn't have before. So most low-income individuals will receive nearly 100% of coverage of their prescription drug costs under the new Medicare drug program with all or most of the premiums being paid by Medicare and this group doesn't have a coverage gap.

And other low-income beneficiaries will obtain large savings from having enhanced insurance coverage and having access to negotiated discounts on their medicines.

[Slide #30] At the same time, however, pharmaceutical companies realized that some low-income individuals may still have some out-of-pocket expenses. And companies had hoped to have more options to assist these individuals including being able to use their PAP, their Patient Assistance Program, to wrap around the benefit at least in the coverage gap. Unfortunately, to answer to your question, this ability appears have been severely restricted. So companies' ability to use their PAPs to help Medicare beneficiaries maybe required to change under the Office of the Inspector General interpretations.

Sandie Dean: What federal law prohibits it? It's not the MMA, is it, John?

John O'Brien: **[Slide #31]** No. It's primarily the federal fraud and abuse laws that pose the obstacle. And these laws provide for civil and criminal penalties for a number of different activities. And prior Office of the Inspector General and I guess OIG's, the term, opinions issued in connection with cost sharing assistance in Medicare Part B had stated that pharmaceutical companies' PAP assistance for Part B drugs were a problem under these laws. We all know that Medicare Part D is structured very differently from Medicare Part B, and PhRMA and its number companies believed that assistance could be provided in a manner wholly consistent with existing fraud and abuse laws particularly with respect to assistance to fill in the coverage gap.

[Slide #32] Now, PhRMA had requested that the OIG issue or clarify guidance that would allow Patient Assistance Programs the option of providing free medicines to low-income beneficiaries enrolled in the new Medicare drug benefit when they're in the coverage gap so long as the assistance is structured appropriately to protect the Medicare program. We supported this request with a detailed white paper explaining how Patient Assistance Programs could both be available to beneficiaries and protect the government's interest. And we understand that many individual patient provider groups had also requested that the OIG issue guidance that would allow manufacturers to continue providing the assistance.

Sandie Dean: And what does the new OIG guidance say?

John O'Brien: **[Slide #33]** On November 7th the OIG released what they call the *Special Advisory Bulletin on Patient Assistance Programs for Part D Enrollees*. And this Special Advisory Bulletin states that manufacturer programs that provide direct assistance to Part D enrollees to insist—to assist with their cost sharing including the coverage gap, pose a substantial risk of violating the anti-kick back law.

And the OIG does provide some example of other ways in which manufactures may provide assistance that provide a reduced risk although each of those options are burdened by numerous conditions or practical considerations that impose significant limits on Patient Assistance Programs' ability to continue providing donated meds to Medicare beneficiaries within their current benefit or PAP structure. So in effect the only option left open by the OIG as relatively risk free is providing direct financial support—not donated medicines—to independent foundations. And to get assurances that whatever new structure they develop doesn't violate the fraud and abuse laws, the guidance indicates that pharmaceutical companies may need to request an advisory opinion from the OIG describing the details of particular programs and these opinions can take months if not longer to obtain.

Sandie Dean: So what are the manufacturers doing?

John O'Brien: [Slide #34] Well, let me just step back and say that as an association we can't collect the information about it or even discuss with our members what individual companies maybe doing with their individual Patient Assistance Program. But generally manufacturers are undoubtedly evaluating the recent guidance. As the guidance came out so late in 2005 and so close to beginning of enrollment in November and the beginning of the benefit in January, each manufacturer may have had to make its own decision about how programs would relate to Medicare beneficiaries at least for the first year of the program without the benefit of the guidance from the OIG.

It's important to know too that this new guidance only affects the way that Patient Assistance Programs provide assistance to Medicare beneficiaries. Patient Assistance Programs provide assistance to many low-income individuals, many of whom are not Medicare beneficiaries, and the new guidance doesn't affect their ability to continue to provide that assistance.

And at the same time, PhRMA and our member companies continue to work with other organizations and government organizations to support the Medicare prescription drug benefit. And we'll continue to look for ways in which manufacturers' Patient Assistance Programs could continue to assist Medicare beneficiaries who are enrolled to Medicare prescription drug coverage consistent with federal law.

Sandie Dean: [Slide #35] Volunteers in Healthcare has a chart at www.rxassist.org on PAPs' eligibility and Part D benefits. Phylis, can you tell us a little bit about how the American Kidney Fund has helped people with kidney disease in the past?

Phylis Ermann: [Slide #36] I'd be happy to do that. The American Kidney Fund was founded in 1971, before Medicare Coverage, to help one patient pay for dialysis. And for over 35 years the fund has adapted to the changing needs of people with kidney failure. In 2004 the fund provided 105,000 grant totaling nearly \$57 million to 55,000

patients. These grants helped patients pay for medication and medication co-pays, transportation to dialysis, health insurance premiums, and living donor expenses.

Sandie Dean: I've heard that help from charities can be used to meet patients' true out-of-pocket costs. How will the Fund help people with Medicare Part D?

Phylis Ermann: [Slide #37] Well with the initiation of Medicare Part D, the Fund has been exploring new ways of assisting people with kidney disease with their out-of-pocket prescription drug costs. Our 35 years of expertise in evaluating patients' financial need on a national basis makes the Fund uniquely qualified to provide this assistance.

Our goal is to establish a funding pool from which grants would be made to patients for their Part D co-pays. We're holding discussions with several pharmaceutical companies about contributing to this pool. As mentioned earlier the recent OIG Advisory indicates that drug manufacturers are at lower risk of violating the Social Security Act anti-kickback statute when they donate to charities and charitable foundations than when they have their own Patient Assistance Programs. The Fund has also requested our own IG opinion on our program for added assurance that it would not violate any anti-fraud provisions.

Patients with limited income who are marginally above cut-off limits for public aid have always been in the funds constituency. Therefore, our Part D program would initially serve dialysis patients whose income falls between 135% and 150% of the federal poverty level. Although Medicare will help this group of patients by providing partial "extra help" for Part D plan costs, they will have significant cost shares for the Part D premium that's based on their income, a \$50 annual deductible, and 15% of drug costs.

As our funding pool increases through grants and donations, we will evaluate expanding the size of Part D patient grants and/or extending grants to those with transplants and patients with chronic kidney disease but not kidney failure.

In the meantime, we will provide limited Part D assistance with our own resources through our Individual Grant Program which will have the same criteria as it always had and ask for our usual protocol. We will accept applications from dialysis social workers and nephrologists. Patients will be eligible for an annual grant of up to \$175 to pay these Part D cost shares.

Sandie Dean: [Slide #38] Other charities and foundations accept donations from pharmaceutical companies and others for people with certain conditions including chronic kidney disease and kidney failure who meet their guidelines.

- HealthWell at www.healthwellfoundation.org helps with Part D co-pays, coinsurance and/or premiums for those who take oral drugs for anemia of CKD or ESRD and secondary hyperparathyroidism.

- Patient Services Inc. at www.uneedpsi.org helps existing Medicare only clients with the 20% Part B co-pays for those with anemia of CKD who take Aranesp[®] or Procrit[®] and pays co-pays and coinsurance for organ transplant recipients taking antiproliferative drugs. PSI hopes to start accepting new applications this year. Check these websites or ask the social worker about other sources of help. Additional resources like these will be posted on the professional links page on www.kidneydrugcoverage.org. Incidentally, charities and foundations typically refer people to others if they can't help.

[Slide #39] As a reminder, payments made for drugs by charities, qualified SPAPs, families, friends, and personal health savings vehicles like medical savings accounts can count toward TrOOP. Insurance payments don't. Plans track and report TrOOP balances to members at least monthly if they're using Part D.

Before we close for today, it looks like most of the questions relate to a couple of topics for CMS and transitioning. Janet, what should a patient do when a pharmacist can't or won't check eligibility and charges dual eligibles or others with extra help full prices for drugs or higher co-pays?

Janet Miller: **[Slide #40]** Well, Sandie, let me say that CMS sincerely hopes the likelihood of this happening is small in comparison to the number of clients being served and the volume of prescriptions being filled. But that doesn't make the situation of being turned away any less stressful so we have implemented some action step to reduce if not eliminate this from happening and that includes

- We've increased support to the pharmacist hotline. Remember, I have said that we have gone from 150 CSR to 4,500;
- We've improved the response time for Web-based tools;
- We are providing guidelines to pharmacists on the Web-based tools to improve their match rates;
- We're working very specifically with the drug plans reiterating our CMS transition policies and asking them to enforce their own (transition plans); and
- We are holding weekly conferences with pharmacy associations.

Now, but we have also set up a system that looks at the turn away issues on a case-by-case basis and we have trained our case workers at the helpline and at regional offices to work with individuals with this problem.

So specifically to answer your question, if duals need prescriptions now and mechanisms aren't working for them, they should call 1800-MEDICARE. They should tell the CSR that they have a medical emergency that they have been turned away and the CSR will either help them directly from that point or will refer the case to the case worker at the regions just as I mentioned.

Sandie Dean: How can we prepare our patients with Medicare savings programs and SSI who will be facilitated enrolled in Medicare drug plans this June?

Janet Miller: [Slide #41] Well, thank you for asking that question. And for the future I ask you all to bear in mind two points: that many of the current problems happened when someone was auto assigned to a plan but later changed their mind and secondly that the number of people who will be transitioning between Medicaid and Medicare, under the scenario you just outlined, will be much smaller and the ratio would be more manageable.

You should also know that later this year in the spring, Medicare is going to mail letters to people with Medicare who qualify for extra help. This letter will inform people with Medicare that because they get SSI (Supplemental Security Income) benefits, or belong to or apply and qualify for Medicare Savings Programs, Medicare is going to enroll them in a Medicare prescription drug plan to make sure they get help paying for their drugs. Now this notice is going to include a cover letter, a list of plans in each region with premiums at or below the benchmark and a series of questions and answers. There are going to be two versions of this notice, one for those who qualify for the full subsidy and one for those who qualify for the partial subsidy. Now, before we send this out to the beneficiaries, we have—we being CMS have—asked advocacy groups to review and comment on the draft version of this letters just to help us minimize any confusion in the real world. So what I need to ask all of you do is to please remind your patients that these letters will be coming, that they contain important information, and if they don't understand them to call 1800-MEDICARE.

And of course, we ask NKF to keep us posted as to the questions and concerns you get from colleagues and patients and this is going to help us pinpoint trends and realize if these things aren't clear.

Sandie Dean: [Slide #42] So that's about all the time we have for today. In review, today we learned some resources that may help to fill the coverage gap for some patients:

- We talked about enhanced Medicare drug plans that may pay more or cover more than standard plans;
- Medicaid may cover all or some Medicare excluded drugs;
- SPAPs offer partial or full wraparound benefits;
- Remember that some states have state kidney programs and that four of these are qualified SPAPs;
- We also talked about the inspector general's advisory that limits help the pharmaceutical companies can give to Part D members without risking sanctions under the Social Security anti-kickback Statute. It seems that companies can contribute to charities with less risk;
- And charities and foundations are also working to develop programs to help pay all or part of eligible individual premiums and cost shares;
- Finally, Medicare is addressing issues with the duals and is proactively planning with advocacy groups for how to transition those who will be facilitated enrolled in June.

Now I'd like to ask Dolph Chianchiano to say a few words to conclude our teleconference.

Dolph Chianchiano: [Slide #43] I would like to thank Sandie Dean, Janet Miller, Marge Watchorn, John O'Brien, Phylis Ermann, and Beth Witten, representing the Missouri Kidney Program today on behalf of Bob Whitlock, for sharing their time and expertise with us for this teleconference.

[Slide #44] As we have said before, Medicare prescription drug coverage will help some people afford drugs they need. Others may not need it. Most of what you read is for the average Medicare beneficiary. However, the Kidney Medicare Drugs Awareness and Education Initiative and its participating organizations have developed kidney-specific information to help patients make informed decisions about whether to join the Medicare drug plan. Those who have or choose plans that cover their drugs will fare a better than those who don't. If social workers ask patients to bring notices they get from government agencies, employers, health plans or Medicare drug plans, they can explain if coverage is creditable, help patients review options and put a copy in their desks for safekeeping. The patients have the right to choose not to bring notices or to join a Part D plan.

[Slide #45] We want to thank you for joining us. We hope this teleconference series has helped you understand more about Medicare Part D. Our motto continues to be the right information at the right time.

[Slide #46] Today's slides are under the teleconference date on www.kidneydrugcoverage.org. Later, we will post the transcript and a presentation that synchs sound and slides in the same place on the Web site. You can register on the slide to get updates about the Web site and other activities. There are four new booklets for patients and a Compare Drug Plans packet on the site now. We will be adding 40 fact sheets based on patients' treatment, finances, and current drug coverage.

Print your attendance certificate and complete an online evaluation from links under today's teleconference date on www.kidneydrugcoverage.org. Check with your licensing agency to see if you can get continuing education credit with this certificate. Submit questions about this topic to info@kidneydrugcoverage.org.

Today's teleconference concludes the current teleconference series. We included the place on our evaluation form this time that allows you to give us feedback on whether you want additional teleconferences and the topics that you might like to see covered in the future. Please let us know what you think.

Thank you for listening. We look forward to your evaluations.