Centers for Medicare & Medicaid Services
National Medicare Education Program Meeting
Moderator: Jill Darling
January 31, 2018
1:00 p.m. ET

Operator: Good afternoon. My name is (Amy) and I will be your conference operator today. At this time, I would like to welcome everyone to the National Medicare Education Program Meeting.

All lines have been placed on mute to prevent any background noise. Throughout the call, there will be times for question and answers. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

I would now like to turn the call over to Ms. Susie Butler. Please go ahead.

Susie Butler: Thanks so much, (Amy), and thank you for helping us moderate today's call. I'm Susie Butler. I direct the Partner Relations Group here in the Office of Communications at the Centers for Medicare & Medicaid Services. I want to welcome you to today's National Medicare Education Program call.

Before we begin, I'd like to go over just a few housekeeping items. For the record, today's meeting is being recorded and the audio recording and presentation materials will be posted to the NMEP website.

This meeting is not intended for the press and remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have inquiries, please contact CMS at press@CMS.hhs.gov.

We've e-mailed the presentation slides to everyone who registered for today's call. In addition, we will also post the presentation slides and the audio recording of today's meeting on the CMS NMEP webpage about a week from today. After the materials have been posted, we will e-mail you a link to access the materials on the NMEP website.

Again, I want to thank you all for joining today's call. We recognize that trusted organizations like yours are on the front lines working to connect individuals to Medicare information, health resources and services. We hope this afternoon's presentations will assist you in this important work.

To streamline things, I'm going to introduce all three of our speakers right now. First of all, we have (Marc Wernick), health insurance specialist in the Division of Training in the Office of Communications. He will explain the many Medicare covered preventive services, screening exams, wellness visits, lab tests, and immunizations that can help prevent, find and manage medical problems.

Next, we'll have Erin Pressley, director, Creative Services in the Office of Communications and she will be presenting on the new Medicare card and will provide information about the new card mailing strategy, mailing contents, card research, along with our outreach planning and materials.

And then finally, we have Carlye Burd, who is a program lead for the Medicare Diabetes Prevention Program, Division of Healthcare Delivery, Center for Medicare and Medicaid Innovation. And she will provide an overview of the Medicare Diabetes Prevention Program expanded model and provide actionable steps for clinicians and suppliers.

We'll take your questions after each presentation. So, now, it's my pleasure to introduce, (Marc Wernick).

Marc Wernick: Thank you very much, (Amy) and Susie. It's really great to be on this call to discuss Medicare preventive services. It's one of my all-time favorite topics to discuss. One is because of Benjamin Franklin who said, “An ounce of protection is worth a pound of cure.” The other reason is that most of the services we're going to be talking about are offered at no cost. No out-of-pocket, no deductible for most services, but we'll get into those details.

This is an informational presentation. Official Medicare Program legal guidance is contained in the relevant statutes, regulations and rulings. This presentation is about 30 minutes with time for questions at the end. The deck

you received or will be downloading it meant as a reference. Because of time, we can't cover all of the preventive services. But, I'll be giving a few tidbits and highlights and provide some context and relevancy as we go through it. The document will be a reference.

Also, I'll be highlighting some resources that you can use with your constituents. Again, thank you for the hard work that you do in building our partnerships.

Finally, I want to invite you to visit the National Training Program landing page where we update our materials on a continual basis. We're now in the process of updating our materials for 2018. So stay tuned.

Let's jump right in. So, we want to keep you well. We want to catch disease early. We want you to be healthy and we want to keep medical cost low.

Preventive services help find problems early when treatment works best. You must have Medicare Part B, that's B as in boy, which is the medical insurance portion of Medicare to access preventive services. These services are covered whether you get coverage from original Medicare and Medicare Advantage Plan or another type of Medicare health plan.

However, the rules of how much you pay for these services and what services are offered may vary. We urge people to talk to their doctors to figure out which preventive services are needed, how often they need them to stay healthy, and if they meet the criteria for coverage based on age, gender and medical history.

We're going to be coming back to a mantra that I always love to kind of put upfront when it comes to paying for preventive services. If you have original Medicare, and here is the mantra: you pay nothing for most preventive services if your provider accepts assignment. I see hands going up in the classroom and you go, "Well, (Marc), what does preventive services and assignment have to do with each other?"

Well, let me define assignment first. I'll read that to you. Assignment is an agreement by your doctor, provider or supplier to be paid directly by

Medicare, to accept the Medicare-approved amount as full payment for coverage services, and not to bill you for any more than the Medicaid deductible and co-insurance.

So, you can go to a provider who doesn't accept assignment, but you're likely to pay more.

Well, inevitably, when I give this presentation, there are two frequently asked questions that come up. Oh my gosh, why did I actually get a bill for lab services? Well, usually, that's because the provider is offering additional test as part of that visit. So you come in complaining about X, they say, "Well, let's just make sure that that's not something to be concerned about." And they'll run an additional lab, which is outside of the discussion of the preventive services.

Also, people ask, "But, why do I have copay? Why does my deductible being tapped?" And that's because certain services, which we'll discuss later on, are outside of the purview of our mantra of paying nothing if the service provider accepts assignment.

All of this information, again, is in the download, but I also want to give a shout out to the "Medicare & You" handbook, which outlines all things Medicare but does an especially good job of cataloguing all of the preventive services that are covered and which ones have a copay associated with them.

I'd now like to take the perspective of a person newly enrolled in Medicare. They've just joined the fold, they're eligible for benefits. And the first thing we want to do is welcome them to Medicare with the Medicare preventive visit.

This is also called the Initial Preventive Physical Examination, IPPE, which is a great way to get up-to-date information on important screenings and vaccines as well as to review medical history. It's offered one time within the first 12 months of enrollment. During that visit, your doctor will review your medical and social history. Things in social history includes who you live with, are you married.

They'll also take a bunch of measurements, your blood pressure, your height, and your weight, and then you'll have a discussion about what your lifestyle is like at home. They're trying to assess potential risk for depression. They're trying to see if you're safe in your home, if you're a fall risk, if you can do your daily activities.

From all of that discussion and conversation, you'll come out with the checklist, and that checklist will help you monitor your health overtime. You'll also get information about preventing disease, how to improve your health and stay well. The doctor will also let you know which screenings and other preventive services are needed to keep you healthy.

Here's an important caveat. OK. So, I'm probably old enough to remember a physical exam. And this is not a physical exam. It's a preventative visit. Routine lab tests are not covered during this visit as part of the free services.

So there's another case scenario: You've had Part B for longer than 12 months. Now, what? Well, good news, you can get a yearly wellness visit and that's covered every 12 months, both the initial “Welcome to Medicare” preventive visit as well as the subsequent yearly wellness visit regardless of how much time you've had in Medicare. It's covered once every 12 months and you'll pay nothing if the doctor provides assignment.

If you had Part B for longer than 12 months, as I said, you'll get an exam very similar to the IPPE, measurements, a review, an assessment, and a plan. So, now that everyone has had their introductory preventive exam, there's now what's called the sequential yearly visit. And during that time, the provider will measure, update, detect, and discuss. They'll measure blood pressure and weight. They'll update your medical history. Chances are your health history has changed and you may have added new providers to your health care team that will be noted in your records. And they'll review risk factors, what's happened over the last year.

They'll also take time to detect whether there's a cognitive impairment that's going on. And that whole visit will then be wrapped up into a discussion of

personalized health advice, which makes referrals as appropriate for counseling and interventions.

In addition to the “Welcome to Medicare” visit and the yearly visit, there's a range of preventive services that are provided. In fact, there are 29. So again, if we were in the classroom, I put up a big sign with all of the 29 services, people would ooooh and aaaah and chances are at least one person will say, "I didn't know that was covered." So there are 29 services, alphabetically I like to say, is from the abdominal aortic aneurysm screening to the smoking and tobacco sensation counseling.

Some of the preventive services are available to all people, we'll discuss that case. Some are available based on gender. And most are based on risk factors. I see a question coming up from the audience, what is a risk factor? A risk factor, puts an individual at a higher risk of getting the disease. It doesn't mean that you'll be getting the disease, it just means that we want to screen you more often so that we capture it early.

Risk factors can include age, predisposition because of an existing condition. Well, what does that mean in English? Give me an example, (Marc). Well, people have high cholesterol and that's a pre-indicator for having cardiovascular disease or risk for a heart attack or a stroke.

Other risk factors include ethnicity and family history.

I know one thing that's always on my mind especially when I come into the building here at CMS, I always make sure that my hands are clean, because we're in the middle of the influenza season. And listening to the headlines, this is going to be an especially difficult season. And something that's available to every recipient and person getting Medicare is the flu shot. A flu, again, is a respiratory tract infection of the nose, throat and lungs. It's dangerous because it can lead to pneumonia.

Medicare Part B covers one seasonal flu shot per season for all people with Medicare. However, there is a couple of caveats with that. Let's take my friend (Jane). (Jane) is always late in doing everything. She just got her flu

shot yesterday. So that would be in January 2018. If she gets a flu shot in October, November or December of this coming year 2018, she can get another flu vaccine because that's the start of a new flu season.

Also, you can get more than one seasonal flu shot if your doctor determines and documents your medical record that the additional shot is both reasonable and medically necessary. Again, for the flu shot, our mantra, you pay no co-insurance and no Part B deductible in the original Medicare if the vaccine – for the vaccine if your health care provider accepts the assignment.

So we just talked about a preventive service that's available for everyone. Let's talk about a preventive service based on gender. January is cervical cancer month. Medicare covers a pap test, a pelvic exam and a clinical breast exam as part of the overall screening service.

These tests are covered for all women with Medicare and are usually performed in the same visit, so you'll get three exams at the same time. They're covered every 24 months for most women. However, if there's certain risk factors, the exam can occur every 12 months. Those risk factors include any one of the following:

- You're high risk based on family history or medical findings,
- You're childbearing age and have had three abnormal pap test in the past 36 months.
- Or things such as:
    - Being HIV positive or
    - Not having had enough screenings in the past seven years for a pap test.

So we talked about something for everyone. We talked about gender. Now, let's talk about risk factors. January is also national glaucoma month. So this gives me an opportunity to talk about a very serious eye disease that has to do with the pressure in the eye and that can cause you to go blind. You're considered at risk for glaucoma if you meet any one of the following characteristics:

- You have diabetes;
- You have a family history of glaucoma;

- You're African American and over 50 years old. And – or anyone of the following including
- You’re Hispanic American, 65 years or older.

This is slightly different than the general preventive services as you need to go through an eye doctor who's legally authorized in your state to perform the exam. You're going to pay 20 percent of the Medicare-approved amount, and the Part B deductible applies. If you're in a hospital outpatient setting, you must pay a copayment.

Another frequently asked question is, oh, does Medicare Part B cover normal eye exam? No, original Medicare doesn't. So, that part is not covered in the copayment or the deductible.

The last screening that I'd like to talk about is diabetes. Diabetes, as you know, is a very serious disease and it's the number one cause of blindness among adults. It's due to a high blood glucose or sugar level in your blood. People at risk for diabetes include people with high blood pressure, high cholesterol and triglyceride levels (that was a mouthful), obesity, people with a history of high blood sugar and a family history of diabetes.

Medicare covers diabetes screening for all people with these risk factors or diagnosed with pre-diabetes. People should talk to their doctor about how often they get tested. For people with pre-diabetes, Medicare covers a maximum of two diabetes screenings within the 12-month period, but not less than six months apart. For people who are diabetic or who have been diagnosed as pre-diabetic, or not been tested, Medicare covers one diabetes screening within a 12-month period.

Medicare provides coverage for diabetes screening as Part B benefit after a referral from a doctor or qualified non-doctor practitioner, for an individual for diabetes. You pay nothing for screening if the provider accepts the assignment.

Medicare Part B, as in boy, also covers some diabetes supplies, including insulin pumps, special food care, and therapeutic shoes for people with

diabetes who needs them. Insulin associated with an insulin pump is covered under Medicare Part B as in boy. Injectable insulin not associated with the use of a pump is covered under Medicare prescription drug coverage Part D as in dog.

In the original Medicare, you pay 20 percent of the Medicare-approved amount after the yearly Part B deductible for the glucometer, the device that measures how much blood sugar is in your system, lancet and test strips.

Medicare also provides coverage of diabetes self-management for people with Medicare who've recently been diagnosed with diabetes or who are determined to be at risk for complications from diabetes. You can also get this diabetic self-management training classes if you've previously been diagnosed with diabetes and just became eligible for Medicare.

Medicare Part B covers up to 10 hours of diabetic outpatient self-management training during a calendar year. You'll get to have education about your blood sugar level, diet and exercise and medication. You need to have an order from your doctor or qualified health care provider who's treating diabetes.

You can also get two hours of follow-up training each year, if any one of the two apply. One is your doctor or qualified provider orders it as part of your care. Or two, it's been a calendar year since you got the initial diabetes self-management training. Also, a little extra thing for people with diabetes, Medicare covers foot exam and treatment if you have diabetes related nerve damage and/or meet certain conditions. You pay 20 percent of the Medicare-approved amount and the Part B deductible applies. Again, if you're in a hospital outpatient setting, you must pay the hospital copayment.

I also want to talk very briefly because I know that later on in the presentation, we'll be giving in some more detail about this. But there is a new diabetes prevention service that's being launched. The Medicare Diabetes Prevention Program is a structured intervention with the goal of helping reduce people with Type 2 diabetes. I'm sorry, is a structured innovation – let's start again, OK.

Policies related to Medicare diabetes prevention services we just established. The Medicare Diabetes Prevention Program is a structured intervention with the goal of preventing Type 2 diabetes in individuals with an indication of pre-diabetes. The program consists of 16 intensive core sessions over a six-month period in a classroom situation. The objective is to make long-term dietary change, increase physical activity, and structure behavior changes for weight controls. After the completion of the class, there's less intensive follow-up meetings monthly.

The goal is to have people lose at least 5 percent of their body weight. The program is based on an NIH study that found that lifestyle changes resulting in modest weight loss changes sharply reduce the development of Type 2 diabetes and people with high-risk for the disease. So look forward to that preventive service coming soon and for more details following.

I now want to turn to the resources that are available to you and to your constituents to help them navigate Medicare preventive services. If I was here, I'd hold up my visual aid, a nice booklet that's prepared with an apple a day keeps the doctor away icon of a nice fresh apple. It's “Your guide to Medicare Preventive Services”. This publication is written in plain language so that people with Medicare can better understand preventive benefits that are covered, the criteria for those that are covered, the frequency of coverage and the cost associated with these services.

There's also a helpful checklist that's available for people with Medicare. It lists all the Medicare coverage services and can help them keep track of when they receive those services for which they qualify. Again, in the information that you're receiving, you'll have direct links to where you can download the information or order it from our publication site. I also am pleased to announce that we have a great resource on the Medicare Learning Network. Prevention services and topics for health care professionals, including coverage, coding, billing, reimbursement and claim filing information can be found on the MLN.

I'll let you in on a secret that my supervisor shared with me. If you Google Medicare preventive services, Medicare Learning Network, you'll get a great

array of Medicare preventive services that you can drill down almost like a bingo board and see what's covered, what's the billing coding is, the frequency. It also has frequently asked questions, resources and other services that are available.

In the document that you'll be able to download, there's also a preventive service resource guide that highlights some of our sister agencies, some not-for-profit organizations like the American Cancer Society, and list six Medicare products that will help you and people receiving Medicare know about preventive service.

So finally in wrapping up, here is the commercial announcement. If you've enjoyed today's presentation, I invite you to visit the National Training Program, we brought you this presentation. You can view all of our training materials on our website, the URL will be given out in the packet. And I invite you to subscribe to our e-mail list and you learn about our upcoming webinars.

Finally, please stay connected if you have questions about training, you can contact us at training@cms.hhs.gov , or follow us on Twitter and that's handle is @cms.gov#cmsntp. So, thank you very much for your time. Again, our appreciation for all the work that you do in the field.

And I believe we'll start off with a couple of questions and then open the line.

Susie Butler: Right. Thank you, (Marc), for your presentation. (Amy), you want to give the instructions for how people can queue up and then I have a couple of questions for (Marc) before we go to the slide questions.

Operator: On the phone, if you would like to ask a question, please go ahead and press star then the number one on your telephone keypad. Again, that's star then the number one to ask a question.

Susie Butler: Thanks, (Amy). So I have a question, what happens if during the wellness visit, the doctor or health care provider performs some additional tests, services, see something they want to pursue? What happens – are things charged, how does that work out?

Marc Wernick: Sure, that's a great question. You have to pay coinsurance and the Part B deductible may apply. So coinsurance is the amount that you require to pay as your share for the service. It's usually a percentage. You'll have to pay a deductible first if you haven't met your out-of-pocket cost for the year.

Susie Butler: OK, that helps. The other thing is at the top of your presentation, you were talking a lot about assignment. And I know a lot of folks were dialing in right then. So, if you could, go back, review slightly, and briefly what is assignment, what is that about?

Marc Wernick: Sure. Let me give the definition once again for people. Assignment means that your doctor, provider or supplier agrees or in some cases, provided but required by law to accept the Medicare-approved amount as full payment for coverage services. Most doctors, providers and suppliers accept assignment but you should always check to make sure. Participating providers have signed an agreement to accept the assignment for all Medicare coverage services.

So, here's what happens. Your out-of-pocket cost may be less, they agree to charge you only the Medicare deductible on the coinsurance amount and usually, they wait for Medicare to pay its share before asking you to pay your share. They also submit the claims directly to Medicare and they can't charge you for submitting the claim.

Susie Butler: OK, perfect. Thanks, (Marc). So (Amy), do we have anybody in the queue for questions for (Marc)?

Operator: You do. You have one question in queue at this time from the line of Victoria Howard of MCPHS University. Your line is open.

Victoria Howard: Hi, can you hear me OK?

Susie Butler: Yes, we can.

Victoria Howard: Fantastic, thank you. So, I have two questions. First of all, you know, in the interest of the topic of discussion of prevention today, I've had this question a

number of times. Does Medicare cover diabetic testing supplies for someone who has not been diagnosed as diabetic just yet, they are being watched closely as pre-diabetic or at high risk?

(Marc Wernick): That's a great question. I don't know the answer to that question, we will circle back with you and include it in our materials after. But that's a really great question. Thank you for sharing that, Victoria.

Victoria Howard: Sure. And can I ask one more quick question?

Marc Wernick: Of course.

Victoria Howard: This question – I've asked this question for many years and never really gotten any answer for folks, unfortunately, here in Massachusetts. Diabetics who do use an insulin pump, they want to know where, besides their local pharmacy, they can get their insulin, they like to get it mail order, they would like to have – be able to have it second bill to their Medigap. This is an ongoing problem in Massachusetts, local team stores, CBS, Walgreens, Rite Aid, they don't – they will bill, they do accept assignment so they will bill to Part B. But the 20 percent, they don't second bill to the Medigap.

So, I've asked this question a number of times from a number of folks, where can diabetics get their insulin, have it bill to Part B and second bill to Medigap?

Melissa Moreno: OK. That's a really good question. So you're specific to the insulin that relates to the pump, so it is Part B, although typically, we do not consider medications to follow with the Medigap. But under those circumstances, that's something we need to look into and also include with our response at the end of the session.

Victoria Howard: Great, thank you.

Susie Butler: Any other questions?

Operator: You have a question from the line of (Sara Chanultman) of (SMCNA). Your line is open.

Sara Chanultman: Hi, I have a question regarding the Medicare which covers – that covers the Dexcom CGMS for diabetes. But why doesn't it cover the Medtronics?

Susie Butler: Again, the specifics are not something that we can go into here. Invite you to send the questions on specific drug coverage into our partnership mailbox, which is on the invitation. We will do our best to run this down or find the experts in the agency, but this is basically a presentation on prevention but not on coverage of specific drugs. So, rather than frustrate folks on that particular question, we'll do our best to run it down after the presentation.

Sara Chanultman: OK.

Operator: And you have another question from the line of (Kay Barbie) of Central Missouri Area. Your line is open.

Kay Barbie: Hi. Back to the insulin for the pumps, what we find here in Missouri is a lot of the local pharmacies don't have a contract to even bill Part B. So it's pretty hard to find a provider to do the insulin for the pumps to Part B and I think it has something to do with reimbursement rates. So when you're looking into that, I just thought that might be something you might want to keep in mind.

Susie Butler: Every little bit helps, so thank you so much.

Operator: Your next question comes from the line of Susan De Abate of Sentara Healthcare. Your line is open.

Susan De Abate: Yes, this is Susan De Abate calling from Sentara. Quick question regarding the Diabetes Prevention Program. So, we have CDC pending recognition, we're getting ready to submit our year's data and then they will respond there. Once we get the next step, is that equal to the preliminary Medicare recognition? Or, are we talking apples and oranges?

Carlye Burd: Hi, this is Carlye, I'm going to be presenting shortly on the MDPP. So – but the short answer to your question is, when you submit your data, your source of data to CDC, the determination will be made then if you meet preliminary and you'll be notified if you meet the – that recognition and therefore qualified to enroll as a MDPP supplier.

Susan De Abate: OK. And at that point then, can we start charging once we are at the preliminary status?

Carlye Burd: Yes, that's correct.

Susan De Abate: OK, thank you …

Carlye Burd: There are – yes, there are some things that you can do now and I will talk about that in my presentation.

Susan De Abate: OK.

Susie Butler: Yes, and let's hold further questions about the Diabetes Prevention Program until after Carlye has presented if we could. Are there any further questions on what (Marc) presented around prevention?

Operator: You have a question from the line of (PJ Difrins) of Northwest Colorado. Your line is open.

PJ Difrins: I was wondering if we can have people have their prescriptions done under Part D for some of their medications instead of under the Part B portion because sometimes their insurance is going to be more beneficial with the prescription coverage.

Susie Butler: You're asking if prescriptions can be billed under Part D instead of Part B, because of insurance company confusion or something else. That is a policy determination depending on hospital and other – there's a lot that goes into that. And we can easily cite that policy for you but you can't just wave a wand and suddenly be under Part D versus Part B. And I don't mean to be flippant about that, I just – there are certain reasons things are prescribed under one program or the other.

PJ Difrins: So would the doctor then have to write a specific prescription to make that accessible, or its Medicare rules?

Susie Butler: It's an individual determination and if the person is in the hospital, they will be billed under Part B. And there are other things that go into that. I think that's

a separate conversation but it's very much Part B as one program, Part D is another program.

Female: There can be crossover in organizations …

Susie Butler: Yes.

Female: … depending on if you're inpatient, depending on if you meet criteria that it is necessary for treatment rather than prevention. So there are all kinds of unique factors that go into each and every physician.

PJ Difrins: Where would I find the policies so I can read up on it?

Susie Butler: I'm going to have to send that to you after this conversation, if you want to send an e-mail to the partnership mailbox, we'll send you a policy citation. How is that?

PJ Difrins: Thank you. That's great.

Susie Butler: Thanks. OK, I think in the interest of time, we need to move to the next presentation because we've only budgeted 30 minutes for each. So, if you have questions that we were not able to get to, please send them to the partnership mailbox that was on your invitation. And we will form those around or shot those around to the appropriate people in the agency so we can get an answer, and we'll share that answer with everybody who's on the call.

All right, with that, it's my pleasure to introduce, Erin Pressley.

Erin Pressley: Great. Thank you, Susie. And thanks for having me back again today. This is, I think, the third time that I've been able to come and talk to all of you about the planning and activities related to the new Medicare cards that we will start mailing this calendar year to Medicare beneficiaries.

And so, in the interest of time, I'm going to skip through a couple of slides in this presentation. I'll let you know when I'm doing that so that you can follow along on your screen or your copy of the presentation.

The first couple of slides, if you've been through any of these presentations with maybe four, are similar just sort of context setting slides and background about the new Medicare cards. I won't go into a lot of detail on those specifics on slide two and three. I think most people by now on this call especially know that we are replacing the health insurance claim number or the Social Security number-based HICN that all people use now as their Medicare identifier with a unique number. We are mailing everybody with Medicare a new Medicare card starting in April of 2018.

So I'll skip through that a little bit. What I wanted to share with you today are a couple of updates. One on some recent research that we've done, and as you know, we've done a couple of different research studies overtime to make sure that we are aware of the place that beneficiaries are in terms of their knowledge of the new card mailing out, the questions that they have and to make sure that our messaging is on track and that we are answering the questions that people with Medicare have at the top of mind, related to these new cards and new numbers.

I'll walk through some of the research. But I wanted to talk a little bit about what this package actually looks like. So, we've gotten questions overtime about the envelope that it will come in and what kinds of information will come with the new cards, so we'll walk though all of that. And then I wanted to give you an update on some of the products that are available that you can use with the people that you serve to help them gain an understanding of what's coming and manage some expectations about timing and things like that.

So, let's jump in on slide four. Let me just walk through our most recent findings in terms of research. In October of 2017, which actually seems like a really long time ago now, we went out with a telephone and online survey. We surveyed about just over 600 Medicare beneficiaries to try to get a sense of awareness of the new Medicare card mailing. And this is a follow up to some extent of an earlier study that we had done in August, before we really started talking about the new cards with the general public. And then we did some things, we released a TV ad that mentioned it. We mailed the Medicare

new handbook. And so we wanted to see by October how much of an impact those things have had.

And as you can see from the slide, we had about a threefold increase in awareness. Still not an especially high awareness that new cards were coming, but remember, we're still about six months out at this time and it's hard to get people's attention about something that far in the future.

So we count this as success, a sort of raving success, and we also count as success that their overall positivity toward these actions really increased. It was high to begin with in our first survey, they felt this was a good thing. They felt it was an even better thing or more of them thought it was a good thing, the second time around when we asked.

And we'll continue to ask these kinds of questions. I won't walk through the first – the specific percentages here. But you can see that we're making an impact in terms of awareness with beneficiaries, which is the goal of our outreach ultimately.

The next slide on slide five, we talk about sort of some of the upcoming surveys, and as I said, we'll continue to touch base with beneficiaries through these surveys and other types of research to see where we are, if we're making an impact, if the question has changed, the answer has changed once the cards start mailing, if the awareness goes up as it should once people start talking about this and they start to see more in their local news and national news about the cards going out.

Just as a reminder on slide six, some of the specifics of mailing the new cards, as I said, will start in April of 2018. All existing beneficiaries will get a new card over the next 12 months of mailings and will distribute those on a randomized geographic-based schedule.

In addition, once we start mailing new cards in April of 2018, any newly eligible beneficiaries will also get a new card with a unique number from that time forward.

So, if you know someone or you're working with someone who, for example, is turning 65 in June, even if the people in their state who are existing beneficiaries, in some cases, people in their household, who are existing beneficiaries, have not yet gotten a new card. That person who is aging into the program at that time will get a new card as well all people after April.

On the next slide, slide seven, I've included a chart that we have posted online as of – about a week ago that sort of shows the different ways the states are lined up. We have previously said that this will be sort of a randomized geographic-based system. We've included a range of mailing dates that are expected for the first few waves of states that does not necessarily mean, for example, that people in Oregon will get cards in April.

It means that people in these two waves of states will get cards mailed to them some time between April and June, so in the first couple of months. It also means that if you were helping people in Mississippi, they will not get cards in April. And so you can probably tone down some of your outreaches because you're in some of these later states.

You'll notice that wave three through seven, at this point, have very big timelines attached to them -- that is intentional on our part. We do expect to release more specifics about the timing of those later waves as we get closer to that time. And as you can imagine, you know, we have the best laid plans and we have the utmost confidence that those plans will work out. But we may be mailing faster than we anticipate, or we may have some delays and so we may need to adjust our planned schedules. And as that starts to firm up, we will make sure that we give you firmer dates for those later mailing waves as we get closer to that time.

On the next slide, I'm going to move into the specifics of what this package looks like. So for existing beneficiaries when you get a new card, what is it that you're actually getting in your mailbox at your home? And the following slides show some mockups of this or actual copies of what we'll be mailing in the package itself. It will be an envelope that includes an insert that has a perforated Medicare card that you carry out of that insert. So the card and the insert have information on them. You also get a letter with instructions in

English on the front and then the exact same instructions in Spanish on the back of that letter. And you'll get a piece of paper that includes some taglines about how to get help in a number of other languages.

So in the next few slides, starting with slide nine, you see some examples of this. For the envelope itself, you'll see a sort of standard white envelope. This is a window address. So the address is not printed separately on the front of the envelope. This is important because this limits or eliminates the possibility that the wrong card will get mailed to the wrong beneficiary, so we don't need to do any, you know, matching game here within address label and the card inside because what's printed on the card insert will show through and be the mailing address.

And then on the back, we have – we're in the process of updating these envelopes so that the outside says, official information from Medicare, which we hope will get people's attention and make them open the envelope, which is our challenge number one, notice and open.

As I said, there's a card inside that contains the (perforated) Medicare cards, and you can sort of see this is the address that will show through. Those Q.R. codes on there are mailing security types of codes. They don't actually go to any kinds of information like Q.R. codes that you would see on the ads, but they are for our printer to help track their mailing.

On slide 11, you see a very, very tiny example of the letter that will be included in there. You can see that it's – again, a one-page letter, very much focused on why I'm getting this card, what I need to do with it, what I need to do with my old card, et cetera.

And then on slide 12 are examples of the taglines and other languages for folks who need help understanding what it is that they're getting, and what they need to do with it, focusing this information on languages other than English and Spanish.

On 13, I just wanted to mention quickly what we're doing for people who have an alternate format preference. So these are folks who have told us overtime as existing beneficiaries that they prefer to get Medicare communications in

something other than a standard format. Maybe they've requested a Medicare handbook in Braille in the past, maybe they have asked for their Medicare summary notices in large prints and we know that about them. We have that information on file in our Medicare enrollment database.

For those folks, we are not going to send them a standard new Medicare card package and then wait for them to ask for an alternate format. We're going to use that information that we have, kind of strip them out of the mail file, put them through another process that includes creating some of these materials in their preferred format and then mailing everything together in a separate package in their format of choice.

So you'll see on the bullet points here, they will get some of those materials in the regular print format that they would have gotten if they didn't have an alternate preference. They'll also get some additional materials in their preferred format that will help them understand and be able to access this information.

And I'll point out that that includes for people with a Braille preference – they'll receive a tactile sticker with instructions about how they can attach that to their new Medicare card since we can't actually produce the cards in Braille for them.

Let's see.

So, on slide 14, just kind of a word about people who need replacement cards. We are still very much out there with messaging, about getting people to update their addresses so that we have accurate mailing addresses on file for them. We will use the address that is our official address on file with Social Security.

If people lose their Medicare card, which sometimes happens, say, if it takes a trip through the laundry and becomes unreadable, they need to get a replacement card. All of our replacement card activities will continue. They will not be interrupted by the mailing of these new cards. However, much like people who are aging into the program, once we start mailing new cards in

April if people need a replacement card, a replacement card will also be the new format with the new number.

And then if people have gotten a new card with a new number and they believe that that number has somehow been compromised, that they are the victim of identity theft, or some type of fraud, they can ask for a new Medicare number or a replacement number of their new number by calling 1-800-MEDICARE. So that's something that's different, a little bit easier if their number is compromised than it is today.

And then the last part I wanted to go through quickly is where we are with our outreach plan. So we have the multiphase outreach plan in terms of outreach and education for beneficiaries, for partners, for providers. We have entered sort of this next stage of that, which really is time to start to ramp up messaging as we close in on starting to mail. As you – many of you remember, when we were in Medicare open enrollment, we kind of intentionally put this on the back burner and made it secondary messaging so that we weren't competing with ourselves and getting people to compare plans and enroll in plans for open enrollment.

Now that that is behind us and we're into January, we've started to ramp up some of our outreach for beneficiaries in particular, and we expect to continue this current phase through about mid to late March, and then we'll shift gears again as we start the mailings.

So the next couple of slides, you see the types of messaging that we'll use for each of those mailings – I'm sorry, for each of those stages of outreach.

And then on slide 17, there's a very tiny chart that goes through the types of outreach products that we expect, outreach touches across our print products, our websites, call center messaging, some of our regional office localized outreach and messaging. I won't walk through those in detail.

And then on slide 18, we talk about the types of materials that we have for people with Medicare. We've released – again, last week, we've released a number of new products, and we have some samples of those on the slides that follow, that we encourage you to use. These are available for download

on our main page, which is cms.gov/newcard. You can find all of the outreach and education materials there as well as all of our technical materials for this project.

We will also have print copies of many of these materials where that makes sense that are available for you to order as well to use in your outreach with your local population.

There's also a video that's now available on YouTube. We've included the URL for that video that's just a nice, short overview video that you could play in offices or send out as a link with e-mails, those types of things.

And so I think I'll stop there, last slide always is the stay connected slide which gives you that URL that I mentioned, the cms.gov website. Gives you the main e-mail address for any questions or comments that you may have about this project and then it also gives you the URL for the information that's on Medicare.gov that's really intended for people with Medicare.

And let me stop there and see if you have any questions.

Susie Butler: OK, great. Thanks. (Amy), if you could have people queue up for questions and then I have a couple of questions while they're queuing.

Operator: As a reminder, to ask a question over the phone line, that's star then the number one to ask a question.

Susie Butler: Great. So while we're waiting for them to get in line, I know that over the past couple of – well, since last week, my team spent sending out information to our partners. But what in your opinion, Erin, are the most important things that partners could be doing right now?

Erin Pressley: You know, I think our two main messages haven't really changed overtime. We're saying them louder and more often right now. But we're still in this stage where we'd really want to make sure the people have a good address on file that we're asking them to make sure they're getting mail from Social Security and from Medicare. And if not or if they've recently moved that

they're contacting Social Security to update that mailing address so that we can get them their new card and not have to worry about that being forwarded.

And then the second message that we're trying to include in that drumbeat is really to watch out for scams. This is always something that we worry about with this population in particular. They're trusting souls and so there are, of course, bad actors out there turning up already to take advantage and collect personal information. We're hearing about some calls being made to beneficiaries and requests for things like their Social Security number or fees to be paid to get their new Medicare card. And so we're asking people to watch out for that and to just reiterate that Medicare is not going to charge you for your new card, we're also not going to ask you for any personal information. We already know everything we need to.

Susie Butler: Well, another thing that came up and you mentioned it earlier that the card is going to be paper. We've heard from a lot of folks, well, can I laminate it? So what's the official word on that?

Erin Pressley: The official word is there's no official prohibition against laminating their cards. They will still be paper like the current cards for a number of reasons. Laminating sometimes interferes with the provider's ability to scan or photocopy that card. And so once you laminate it, it's hard to unlaminate it.

What we would highly recommend for folks who want to protect their paper Medicare card is to buy one of those plastic sleeves that are available in the dollar store or your local pharmacy that you can insert that card into, kind of like a credit card protector. And then they can slide their paper card in and out if they happen to go to a provider that has trouble accepting a laminated card.

Susie Butler: Well, with that, we'll go to the line, see if anybody, (Amy), is in line to ask Erin a question.

Operator: Yes. You have several questions. Your first one is from Micki Nozaki of California Health Advocate. Your line is open.

Erin Pressley: Are you on mute?

Operator: Micki, you might be on mute.

Micki Nozaki: All right. Can you hear me?

Erin Pressley: Yes.

Micki Nozaki: Oh, great. All right. Again, thank you, Erin, a lot of really good information.

One thing that does maybe provide some question or confusion is around some of the documentation that you put out, especially the one page, 10 things to know. On items six and nine, you talked about always carrying your card. And as you know, Senior Medicare Patrol programs across the country always tell their beneficiaries not to carry their card with the exception of when you go to the provider the first time. So, can you help me understand what is CMS's position about that?

Erin Pressley: So we have lots of questions about that. And in the past, we've also encouraged people not to carry their cards and Social Security has told them not to carry their cards because it has their Social Security number on it. So that was our primary reasons for asking them not to carry it.

There's still, of course, a threat with this particular number as there is with any health insurance member number of medical billing fraud if someone gets a hold of that number. There's little to no risk of personal identity fraud if somebody gets a hold of your Medicare card with your new Medicare number. It's hard to tie that back. It's not impossible to tie that back to an individual.

So we are asking that people carry these cards with them. What we found is that many providers have told us that – it's very difficult for them if someone does not have the card. We do have mechanisms for them to find their new number, but it's much easier if somebody has the card with them, not only at a doctor's office but also at a pharmacy or if they get referred to somewhere else for a test. If they have it with them, it's just easier for the providers to be able to supply them with services without delaying that for the beneficiary.

And so, since the risk is lower with these new numbers, we're encouraging people to carry it with them.

Next question.

Operator: OK, your next question comes from the line of (Deborah Brennan) of AAPC. Your line is open.

Deborah Brennan: Hi, actually, this just follows on to exactly what you were just talking about the provider being able to look up the information and that's basically where I was going here. We deal with a lot of nursing home patients in the practice that I'm with. And will we be able to look up their new Medicare numbers, say, going into another test solutions by entering their old number in order to get their charts updated?

Susie Butler: So there are a number of ways that providers will be able to access a beneficiary's number. So I have a colleague here that works more closely with provider communications and with that type of accessibility for the new Medicare Beneficiary Identifier. So I'm going to turn things over to (Tricia Rodgers) here.

Tricia Rodgers: All right, so thanks for that question. If Medicare-enrolled provider has access to their Medicare Administrative Contractor or MAC, you can enter the MAC's portal beginning in June 2018, enter the beneficiary's first name, last name, date of birth, and Social Security number, and you can get back the new MBI, Medicare Beneficiary Identifier.

Deborah Brennan: OK. All right, thank you.

Tricia Rodgers: You're welcome.

Susie Butler: Next question.

Operator: Your next question comes from the line of (Cardy Rooch). Your line is open.

Cardy Rooch: Hi. I was just wondering currently the HIC number discerns whether or not someone is in a Railroad Medicare plan or not. Does the new card have an identifier for Railroad Medicare?

Erin Pressley: So the new card does. The new number does not. So, the new …

Cardy Rooch: OK.

Erin Pressley: … unique numbers that we are providing for beneficiaries are not considered smart numbers, those individual letters and numbers don't have any kind of secret decoder ring behind them that tells you about how a beneficiary is eligible.

However, much like our current system, the Railroad Retirement Board will mail these new cards to their beneficiaries, which I think is around 500,000 people in the country – of the people with Medicare. And those cards will have the Railroad Retirement Board seal on them instead of the Health and Human Services seal. And they will also say, Railroad Retirement Board on the front of the card.

Cardy Rooch: OK. Thank you.

Erin Pressley: You're welcome.

Operator: Your next question comes from the line of Mike Klug of SMP Resource Center. Your line is open.

Mike Klug: Hello. Erin, I have a question about the campaign. Are the regional offices taking any kind of unique role in the public awareness campaign that you guys are rolling out here?

Erin Pressley: So thanks, Mike. I'm glad you asked that. They are, actually. Our regional offices are doing a lot of localized outreach and especially targeting areas in a couple of ways. So, one, when we look at the mailing schedule moving forward, the regional offices will be sort of our feet on the ground in local communities. They will know when those cards are mailing in that community.

So for example, if I'm a regional office person out of our Philadelphia regional office, I'm not going to go out and do a lot of events in Pennsylvania if I know

that Pennsylvania cards aren't mailing for a few more months, even though our national campaign won't be able to be that specific.

So they're going to be creating events and outreach opportunities that align with that date, expected mailing date, they're also doing a lot of our outreach to limited English audiences, so they are working closely with us. You might have noticed in the slides that a number of our materials are available in languages beyond English and Spanish. And we're translating those into languages that our regional offices have identified as places that they really want to do some additional outreach where there are packets of people who speak that language, that they're essentially concerned about as vulnerable populations. And so they're going to be focusing some attention there, too.

And then the last thing that I'll mention is, they are our primary liaison with local press. So they really know the sort of local papers that are out there, the online next door sort of, you know, online services and things and can get the word out through earned media and through other types of outreach to those local news outlets and sources.

Mike Klug: Thank you.

Susie Butler: OK, one more question, (Amy).

Operator: Your next question comes from the line of (Priscilla Grace) from the University of Maryland. Your line is open.

Priscilla Grace: Hi. My question is regarding the Medicare card. I know different consumers that have the AARP Medicare complete card. So will their cards be updated and revised also?

Erin Pressley: So they will not. The individual plan cards that come, if someone enrolls in, for example, in Medicare Advantage or Part C plan or they have a prescription drug discount card or they have a Part D prescription drug plan cards. Those are all supplied and provided by the individual issuers or plans that supply that coverage. So these are replacements of the government issued Medicare card that goes to every Medicare beneficiary regardless of whether they enroll in an Aetna plan or something like that.

Individual plans are working closely with us to make sure that they are also reaching out to their members to encourage them and amplify our messaging and make sure that they don't destroy the wrong cards, and that they continue to bring their appropriate plan cards when they come to see their providers as well.

Priscilla Grace: Thank you.

Erin Pressley: You're welcome.

Susie Butler: Erin, thanks so much. I know some of you has still have questions so I'd encourage you to send them to the partnership mailbox that is on your agenda, partnership@cms.hhs.gov, and we'll do our best to make sure you get an answer.

So with that, I want to now turn to Carlye Burd. She's going to talk to you about that diabetes program we hinted at earlier. So Carlye.

Carlye Burd: Thank you so much. Hi, everyone. My name is Carlye Burd and I'm really excited to talk to you today about Medicare Diabetes Prevention Program. This is actually the first public presentation since we've gone live with implementation and enrolling the DPP organization. So this is very exciting for myself and for the team that I've been working on this so tirelessly for the last two years. So, hopefully I can provide you some timely and helpful information.

So if you go down to slide three, the objectives of today's presentation is to get everyone familiarized with how the Medicare Diabetes Prevention Program, and I'm going to be using MDPP, as you know, at CMS, we like to throw around a lot of acronyms here. So, MDPP in the broader Medicare context. I'll then go over some of the specifics of what Medicare is covering under the new preventive program. And I will talk about what Medicare is paying for this program as well as the requirements of the organizations that will be enrolling and providing these services to beneficiaries and we're calling those suppliers.

I'll then leave you with actionable information that you can take back to your organization about what you can do now to either get ready to enroll in Medicare, enroll in Medicare or educate your patients or your organizations about the Medicare Diabetes Prevention Program.

So next slide, slide four, this slide provides an overview of kind of how Medicare and the Diabetes Prevention Program came to be. And what the MDPP is, at its essence, is a new preventive service that Medicare is covering in response to the rising rates of Type 2 diabetes among older Americans. I think everyone is well aware of the huge and growing problem of Type 2 diabetes, about a quarter of American, 65 and older, are currently living with Type 2 diabetes and this is detrimental to their health.

Care for these individuals is very costly. Medicare have estimated that this cost about $104 billion annually, it's huge and this number will only go up if we don't do something to curb this problem. So the innovation center here at CMS is in – was in a unique position to address this problem. We put out a lot of different types of payment and delivery models to test innovative types of care.

So back in 2013, the DPP model test was conducted in coordination with the why USA and the CDC. And what that model test did was it looked at the CDC's National Diabetes Prevention Program, behavior change program which is a one-year program where individuals work with coaches in community settings over the course of the year to learn behavior change strategies to try to get them to lose weight.

The results of this model test, which went for a couple of years, were very positive in that about 50 percent of those beneficiaries that participated in the model test were able to lose at least 5 percent of their body weight and we know that that 5 percent is the clinically significant amount that's associated with the reduction in diabetes risk.

So those results were positive enough for us to meet the criteria for expansion of this behavior change program to the rest of Medicare nationwide. And we did that through two rounds of rulemaking to establish coverage of the

behavior change program to all Medicare beneficiaries, in addition to establishing a new provider type called an MDPP supplier. And these are the new providers that will be furnishing services in their communities and helping us address the growing problems [of type 2 diabetes].

Now, the impact here is twofold, we are obviously trying to reduce Medicare cost associated with diabetes but more importantly, we are trying to promote healthier behaviors among Medicare eligible beneficiaries to really reduce their risk for Type 2 diabetes, which we know has a trickle-down effect for many other types of chronic conditions.

I will just say here that this is a brand new program for Medicare, so we're just at the beginning stages here. I'll talk more later about kind of where we're at but we've just started to enroll the first providers and this will take years to kind of see some of the results. But we do expect there to be a pretty large impact both in terms of reduction and rates of diabetes for those who participate in these services as well as a substantial decrease in cost associated with their care.

So onto slide five, the slide shows what Medicare is covering for this new preventive service. Medicare will cover up to two years of MDPP sessions for those who are eligible. And the sessions are broken out really into two main phases. I know that this slide shows three phases.

The first phase is the first two bars where you see core sessions and core maintenance sessions. And that is called the core year and that is the year where beneficiaries are really working with coaches to get that 5 percent weight loss or more. So the first six months is a more intense learning curve where they meet weekly with their coaches in a classroom-based setting and they learn physical activity routines that they can incorporate into their daily life. They learn nutrition information and how they can change their eating habits and really that's the intense of learning period (those first six months).

In the second six months, those are follow-up sessions to reinforce the learnings of the first month. And those are monthly sessions.

For beneficiaries that are able to meet that 5 percent weight loss, they can go on to additional follow-up sessions for another year following the first year. So they can attend up to two years of sessions under the Medicare program.

A few things to note here, for that first core year, everyone who's eligible for MDPP services is eligible for that whole year. After that first core year, only those people who are able to meet that 5 percent weight loss can go on to the follow-up sessions, and that, you know, brings a little skin in the game for the beneficiary to continue to keep that weight up or maintain their weight loss so that they can keep their coverage for these services.

There's no copay for any of these services. This is a preventive service, so no out-of-pocket cost. I know someone was talking about assignment-related services earlier. There will be no ability for the provider to charge beneficiaries in any case, because these are – they have to accept all charges for MDPP services. I thought I'd throw that in since we were talking about that.

These sessions have to follow a CDC-approved curriculum and that's really to ensure that these organizations are delivering high quality and evidence-based services to beneficiaries. There's also some flexibility for organizations offering MDPP. They can offer individuals virtual makeup sessions if they can't attend an in-person session. And that's something that we heard a lot from stakeholders because the first six months are weekly, then it goes to monthly, it's oftentimes difficult for beneficiaries to come to every single session. So this allows a little flexibility for people who can't meet for a session and need to do a makeup but wants to stay covered.

The next slide, slide six, this is a very busy slide. The important thing here for you to know is that beneficiaries who have either Part B or Part C coverage are eligible for these services. For Part B, the organizations who will be providing the services will enroll in Medicare and submit claims directly to Medicare. For Part C, the organizations will still have to enroll in Medicare, that is something that is maybe different than other programs, but those claims then would be submitted to the Medicare Advantage Plan and under the Medicare Advantage Plan payment schedule.

So, I think just for anyone out there that is part of a DPP organization or thinking of offering the service, what I'm talking about today in terms of the payment schedule is pertinent to Part B only and Medicare Advantage Plans can set their own payment schedule.

Onto slide seven, the slide talks about the unique roles that CDC and CMS play in the Medicare Diabetes Prevention Program. So I mentioned earlier in the DPP model test we had originally coordinated and worked with CDC, we are really building off of the CDC's existing National DPP program. And basically, paying for the program that they are already administering and they – what CDC is doing for us is really acting as the quality assurance arm for CMS. And CMS is really acting as the payer here which is our typical role when it comes to health care services.

So, just to get a little bit more detailed here, what that means in terms of quality is that CDC has some standards under their National DPP program that the organizations have to meet in order to gain recognition and stay recognized. There's also a curriculum requirements that the CDC sets, again, based on best practices and the almost 20-year evidence based that is behind the Diabetes Prevention Program.

On the other hand, CMS is enrolling those CDC recognized organizations as MDPP suppliers. And again, we establish that through our rulemaking, this is a new provider type but they have to first have that CDC recognition.

We are also establishing who is eligible, to which beneficiaries are eligible and what is covered so what I just went over in a couple of slides ago, and we are also establishing the payment amounts and structure and all the billing and claims processes.

So, hopefully that clarifies, I know we get that question a lot, what is the difference between the National DPP and the Medicare DPP. The Medicare DPP is covering what the National DPP already offers in the community and organizations are part of already.

So, onto the next side on MDPP payments, CMS is taking a performance-based payment approach for MDPP services and that means that we are paying for beneficiaries to meet certain attendance and weight loss milestones along the way as they participate in the sessions. These payments go through the suppliers, they don't go to beneficiaries. And the goal here is to really, again, incentivize the organizations who are providing these services to work with beneficiaries as much as possible to meet these milestones and the milestones that we have chosen are connected to have – to encourage retention in the program as well as that weight loss that is associated with the reduction in diabetes risk.

So, in this table, and I won't, you know, get you – get into the nitty-gritty here. But, what you should take away from here is during the first six months, during that core year in the first six months, when individuals are first starting the program, they're learning, they're really getting to understand how they can work in some behavior change and weight loss strategies, CMS is paying for those sessions based on attendance only.

So, individuals have to attend certain number of sessions in order for CMS to provide payments, and the payments here are listed. They can range between $25 and $90 if a beneficiary attends up to nine sessions.

During the second six months, those payments switch to be much more performance based and focused on weight loss. So there are two $60 payments available for those core maintenance sessions for every three months of both attendance and weight loss being met versus $15 payments, which are for attendance only during those maintenance sessions.

After the first year, there are additional $50 payments for ongoing maintenance intervals. And again, those are three-month intervals and $50 is available to the suppliers if they're able to both meet the weight loss and attendance milestone.

And you'll see here at the bottom of that table the largest payment associated with the service is for that 5 percent weight loss and that is $150 payments.

Again, going back to the value that that 5 percent weight loss outcome carries in terms of reducing Type 2 diabetes risk.

So, onto the next slide, slide nine, supplier enrollments. The main – the most important thing about supplier enrollment is that CDC recognition. The CDC recognition is a prerequisite to supplier enrollment.

So, any existing provider that already has an enrollment with Medicare will need to obtain either preliminary or full recognition prior to enrolling as an MDPP supplier and that enrollment will need to happen again. So they can't use existing provider enrollment. This is a new enrollment based on a new set of criteria that we established.

And again, just going back to trying to maintain the fidelity of the program, making sure that we can provide high quality services. So, the preliminary recognition is the first step and it can take – it takes a minimum of year's worth of data to CDC to obtain the preliminary recognition. And then the second step is full recognition.

So, I included a link here where you can find more information about the recognition process. There are a number of supplier standards in addition to meeting these recognition criteria, and these are really focused on ensuring program integrity and protecting the beneficiary. So things like protection against cherry-picking and lemon-dropping, making sure that anyone who is eligible for the service can access it by prohibiting the organization from denying people access if they are eligible.

So there's – there are a number of those there and they're listed on the enrollment application. So if any of you out there are planning to enroll or want to learn more, you can – there's some links at the end of the presentation to look at that enrollment application and see those supplier standards.

So onto the next slide, the timeline side, we are in January. So, we are already beginning to enroll suppliers. Prior to January, we were really in the policy design and rulemaking phase. So, what I think is important here to realize is we are beginning to enroll MDPP suppliers now, those that are eligible and have met that CDC criteria.

We will begin services as of April. We have to have some time to allow the new organizations to enroll. Most of them are new to Medicare. So – and any provider regardless of whether they have a Medicare enrollment has to reenroll as an MDPP supplier.

So, that three-month buffer allows some time for enrollment, but enrollment doesn't end there. Enrollment will continue. There is no end date. So, we do expect there to be a pretty gradual uptake of the service as new suppliers become familiarized with the program and begin to enroll in Medicare.

So onto my last slide, how you can make MDPP a success. So, I mentioned earlier there's many actions that you can take now. If you are like the caller that asked a question earlier, if you are a CDC-recognized DPP organization, check your recognition status. If you have full or preliminary recognition, then you are eligible to enroll and you can begin enrolling now through the online system called PECOS.

And we highly, highly recommend online enrollment through PECOS versus paper enrollment. It will take a lot less time and be more streamlined.

For diabetes prevention stakeholders, you can help us get the word out. So you can encourage organizations to work to become CDC recognized. We're really trying to build the pipeline right now of organizations that are prospective MDPP suppliers so we know there's a lot of FQHCs out there or community health centers, other types or organizations, a lot of health systems and clinics, existing providers that are in a great position to offer these services and it would be a great addition to their care portfolio.

So, those organizations can begin to work toward CDC recognition, and if they're not currently enrolled in Medicare becoming familiarize with the enrollment and billing processes. And we have a bunch of resources available on our website that walks you through on those steps.

If you are a clinician, then the most important thing here is to become familiar with the beneficiary eligibility criteria and the coverage of MDPP services. So, in addition to having either Part B or Part C coverage, beneficiaries have

to meet certain levels in their blood tests as well as BMI levels. And there's some resources I can direct you to for that as well on our website.

You can also start educating your patients on screening them for pre-diabetes and encouraging them to participate in MDPP once the services go live. We know from some research that CDC had done that only about 15 percent of individuals who have pre-diabetes know that they have pre-diabetes. So the awareness is very low. And we really are going to be looking to the physician community to really help us in creating those referrals to MDPP services.

Right now, the way you can find out which DPP organizations are in your region, you can go to this website that's listed on the slide to get to know local DPPs. This is the CDC's registry. We are working on putting together an MDPP supplier map once we have our suppliers enrolled in Medicare. So, that can be a tool for physicians to use for referral – referring their beneficiaries.

I want to put a plug in for our website and our listserv. So there's a listserv you can sign up on – sign up for in our website. Go here, go.cms.gov/mdpp. You can sign up for updates. You can also scroll down. There's a ton of resources there, including a step-by-step process for individuals who are part of organizations that are in pending recognition.

So, there are some steps you can take now like getting NPIs, getting an I&A account that proceed the PECOS enrollment. So we have an enrollment fact sheet there that provides some great info. And then we also recently posted an enrollment checklist that can help facilitate your enrollment process once you have started enrollment to your PECOS.

So, definitely, check those out and sign out up for our listserv. We will be sending e-mails when we post new resources, so you can stay up to speed on all of the guidance that we are putting together to help these new suppliers and walk them through the Medicare processes. So with that – and by the way, if you go to the end of my presentation, there are some key resources listed there, just link to, so you can look on the slide only and find out some more resources to link to. But with that, I will turn it over to questions. Yes.

Susie Butler: OK, great. Thank you, Carlye. And (Amy), if you could repeat one more time how people can get online for questions. We won't have time for many, but we'll take three or four.

Operator: And again, to ask a question, that's star then the number one on your telephone keypad.

Susie Butler: So while people are queuing up, I have a couple for you. You mentioned that – tell us again what parts of Medicare cover this new program?

Carlye Burd: Yes. It's – so, Part B. So, anyone who has Part B coverage or Part C coverage, so basically getting their coverage though Medicare Advantage Plan. If they have Part A only, they're not eligible.

Susie Butler: OK, perfect. And what do beneficiaries need to meet to be eligible for that ongoing maintenance session? You mentioned that as well, but let's go back.

Carlye Burd: Yes, yes. So that's a really good point. So, the first core year, as I mentioned, are – that's available to anyone who's eligible. But after that first core year, beneficiaries have to meet at least 5 percent weight loss and maintain that in order to go on to the second year of follow-up services, which we're calling ongoing maintenance sessions.

Susie Butler: And one last question. This is mainly for people who are pre-diabetic, not diabetic?

Carlye Burd: Yes.

Susie Butler: OK.

Carlye Burd: Yes. So, individuals who have diabetes are not eligible to participate, unless it was – unless they had gestational diabetes.

Susie Butler: Right, right.

Carlye Burd: That's the only exception to that rule. But if they've had or have Type 1 or Type 2 diabetes, they're not eligible for that.

Susie Butler: All right. Thanks, Carlye. (Amy), do we have some folks queued up?

Operator: You do. Your first question is from (Kris Gross) of HSIIT. Your line is open.

Kris Gross: Thank you. Just a clarification on people who are eligible. If – you mentioned that only 15 percent know that they're pre-diabetes. So, the test you mentioned, blood levels, NPI that people have to meet to qualify as pre-diabetes to get in this program, is Medicare going to pay for those tests?

Carlye Burd: Yes. So, there's three ways, there's three tests. Medicare currently covers two of those three tests. We cover the fasting blood glucose test and the oral glucose tolerance test.

Individuals can use the hemoglobin A1C test also, which I know is a commonly used test. Unfortunately, at this time, Medicare only covers that test for individual that have diabetes. So, they can pay out of their pocket for that test and use it to get into the program.

Kris Gross: So, any provider – if a person wanted to see if they get qualified, they could go into their provider and ask to have one of these tests done.

Carlye Burd: Yes.

Kris Gross: And that would be covered?

Carlye Burd: Yes, like I said, this first two that I mentioned, the fasting blood glucose and the oral glucose tolerance tests. And they can get those tests done within a year of starting the program.

Kris Gross: Thank you.

Operator: Your next question comes from the line of (Gwen Bean) of Parish Nurse. Your line is open.

Gwen Bean: Oh, thank you. Carlye, I have a question. At the very end of your presentation, you have resources, and something that caught my eye, something about understanding fingerprinting requirements. What's that all about?

Carlye Burd: Yes. Thank you for asking that. So, the organizations that will be enrolling in Medicare, because this is a new provider type, these organizations are going to be enrolling under what's called a high-risk screening. So this has nothing to do with the beneficiary. This has everything to do with the organization that enrolled. And the organization that's part of the enrollment process have to submit fingerprints of those in the organization that have at least 5 percent direct or indirect ownership.

And there were a lot of questions that we got about non-for-profit status. Since non-for-profits typically don't have owners, they have board members, so we put together these FAQs to try to clarify the rules around fingerprinting and enrollment and how 501(c) (3) organizations fit into that – into those requirements.

Gwen Bean: Oh, OK, all right. I could open it up and look at that a little bit more. That's new to me. But thank you.

Susie Butler: All right. (Amy), we'll take one more question. And for those who are in queue and your questions haven't been answered, please submit it to the partnership mailbox.

Operator: And your last question for today comes from the line of (Michelle Liss), a senior Medicare partner. Your line is open.

Michelle Liss: Hi. Thank you for sharing this information. I was wondering if you know about any research on the barriers for the success rates for those participants who have not reached that 5 percent weight loss milestone.

Carlye Burd: So, I can't say anything off the top of my head. There's probably a fair number – there's probably a lot of research out there. I am not the expert here in this research area.

CDC may have some more information about that. In fact, CDC in their role with us in this program, really, they do work with organizations to try to introduce strategies to increase the numbers of individuals who meet that 5

percent weight loss as you can imagine. As we all know, as human beings, weight loss is not easy.

So, I think it's one of the hardest things actually. So, I would definitely look to the CDC and the DPRP program, the Diabetes Prevention Recognition Program for some information and research there.

Michelle Liss: OK, great. Thank you.

Susie Butler: Well, thanks, everyone. That concludes today's meeting. We appreciate you joining us and we hope the information we've presented has been helpful.

We're interested in learning more about the topics you'd like to more about at our future NMEP meetings. So please feel free to e-mail your suggestions or any additional questions from today's presentations to our partnership mailbox at partnership@cms.hhs.gov. We look forward to hearing from you and we look forward to visiting with you in about three months. So take care.

Operator: That concludes today's conference call. You may now disconnect.

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