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STATE AND CONSUMERS AFFAIRS AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

# Subcommittee on Medicare Drug Benefit Plans

Summary of the Meeting of November 30, 2006
9:35 a.m. – 12:02 p.m.

Present: Stan Goldenberg, RPh, Chairperson and Board Member
Andrea Zinder, Board Member

Staff: Virginia Herold, Interim Executive Officer
Anne Sodergren, Legislation and Regulation Coordinator
Robert Ratcliff, Supervising Inspector

Chairperson Goldenberg called the meeting to order at 9:35 a.m.

Lucy Saldana, PharmD, of the Centers for Medicare and Medicaid Services, provided a Power Point presentation of changes in the Medicare Part D Program coming January 1, 2007. She stated that patients can change plans through December 31, but that December 8 is really the deadline to assure the desired plan is in effect on January 1.

Dr. Saldana highlighted several features available from the CMS Web site. She said that especially beneficial for pharmacists is the "Part D Reference Guide for Pharmacists" available from www.cms.hhs.gov/pharmacy. This document contains plan contact lists, information on Parts B and D, guidance documents and other items that will aid pharmacists in working through details of the plans.

The list of plans in California can be obtained from www.medicare.gov/medicarereform/local-plans-2007.asp.

Dr. Saldana stated that average premiums for Part D plans will be $24 per month in 2007.

She added that other resources are the CMS Help Line 866-835-7595, which is available 24 hours per day, seven days per week. Help available from this line includes: (1) confirmation of Medicare eligibility, (2) beneficiary enrollment, (3) plan contact information and (4) urgent caseworker assistance for beneficiaries.

CMS has information on plan performance from its Web site. Five areas are reported: (1) customer service (beneficiary and pharmacy help desk call center wait time), (2) complaints (complaint rates for benefits/access, enrollment/disenrollment, pricing/co-insurance), (3) appeals (appeals processing and timeliness), (4) data systems (prescription data, LIS match rate), and (5) prices (availability of drug pricing on the Medicare Prescription Drug Plan Finder and price stability index).

Dr. Saldana stated that CMS is moving to a new audit strategy, where the focus of audits will be determined by data, complaints, compliance history, and experience in the program.

Tim Cutler, PharmD, of the UCSF School of Pharmacy, stated that UCSF has an active pharmacist intern counseling project underway where interns aid patients in selecting the Part D plans that are best for them. He commented that when problems are noted with the plans' information listed on the Web site and the problems are pointed out to CMS, CMS indicates that it is the plan that needs to fix the problem. Dr. Cutler indicated that CMS lacks the ability to enforce plans to make changes in their Web sites. A lack of policing the plans by CMS is a problem.

Teri Miller, PharmD, of the California Department of Health Services, spoke about the department's activities since the implementation of Part D. She stated that early in 2006 California implemented an emergency drug benefit to ensure prescription coverage for patients during the start up phases of the Part D Program. The emergency drug plan will expire January 31, 2007, unless new legislation is introduced to extend it, and she is not aware of legislation planned for introduction to extend the emergency coverage.

The emergency drug benefit provides coverage for medicine to patients where the Part D plan is unable to authenticate whether the patient is a member and covered for the drug. In recent months, the number of claims submitted to this program has dropped dramatically. Now only 50 claims per day are submitted.

In recent months a significant improvement regarding emergency coverage allows the pharmacist to certify that the doctor said he or she called the plan for a prior authorization; however, the specific copy of the prescriber signed prior authorization form does not need to be submitted to secure emergency drug authorization from DHS.

Dr. Miller stated that 300,000 dual eligible patients will be reassigned to a new plan in 2007, but benefits will remain the same. There are two plans for the duals that are offered by United and Healthnet.

Information on this program and polices can be obtained by going to www.medi-cal.ca.gov and select "emergency drug."

She stated that the "claw back" will cost California $54 million more than California would have paid last year without the Part D plans and using the old MediCal program. This difference is projected to grow to $74 million in 2007.

Dr. Miller stated that home infusion remains a problem and SB 676, which was enacted in 2006 would create a bundle service for reimbursement.

Barbara Biglieri, California Association for Health Services at Home (CASAH), stated that her agency represents over 500 providers of home care services.

She stated that home infusion patients are not covered under Part D and this is a problem for the patient who no longer has coverage for supplies, equipment and services when discharged from a hospital to home care.

Pharmacists spend hours trying to work with the plans to get necessary coverage for patients, but the staff of the plans does not understand home infusion or it takes multiple days to get coverage. This results in the patient spending an additional one to four days in the hospital. Not all the services are covered and drop shipments of medications directly to patients from mail order pharmacies require the patient to mix medicine themselves, which is unsafe.

Ms. Biglieri stated that CASAH sent a letter to CMS explaining the benefit "did not include coverage for the home infusion professional services, supplies and equipment that are required for the safe and effective provision of therapy" resulting in denial of the benefit. CASAH suggested that home infusion pharmacy be a professional service under the Part B Medical Benefit or for creation of a demonstration project. The CMS response was nonresponsive.

The CASAH has two suggestions:

1. Push CMS and Congress to move Medicare from Medicare Part D to Part B, and then expand therapy offered. In the interim, have MediCal pay for infusion services for the dual eligibles.
2. Work with the Department of Health Services to implement 676 (Ashbury, Statutes of 2006) to ensure that MediCal beneficiaries receive infusion therapies in a home setting rather than in an institutional setting.

Mike Rigas, PharmD, of Crescent Healthcare, Inc., provided a summary of services it provided in 2006 to over 700 home IV patients. It received $9.1 million in revenue from 26 plans, and $80,000 in patient co-pays, since most patients have a secondary, supplemental or MediCal payor to pay out-of-pocket expenses.

Only 10 percent of the patients can afford this treatment without a supplemental insurance. It may take five to seven business days for authorization for complex therapies.

Dr. Rigas stated that current billing practices make no sense and need to be modified:

- TPN billing is based on charging 2.5 L of one item, not the other 20 items in the solution.
- Multiple ingredients prescription billing is based on the most expensive component only.
- Plans require billing and denial of Part B before they will pay for medication under Part D.

There are 43 new plans for California in 2007.

Dr. Rigas concluded:

- Part D does not provide adequate coverage for home IV therapy.
- Part D alone is only able to support home infusion, all other drugs are inadequately covered.
- Nuances between Parts B and D are still a problem for most patients.
- Part D payor rules and exclusions are confusing to most patients.

Dr. Rigas suggested:

- Place a cap on the catastrophic part at $4,000 per year.
- Mandate payment method to prescription drug plans and Medicare Advantage prescription drug plans so reimbursement remains adequate.
- Reorganize how Part B and D relate to each other to benefit patients.
- Allow Part D to pay an infusion per diem.
- Allow Part A nursing to pay for infusion nursing.
- Restructure Part B to allow payment and drugs per diem.
- Limit number of plans available in a region.

Maggie Dowling, a patient, described her problems with Part D. She stated cost of living increases in her social security go straight into higher copays for drugs. She has no money to cover the copayments now, and moreover, the increasing amount of the copayments will make it even harder. She takes 17 medicines, and the 2006 $1 copay for each medicine causes creates expenses too high for her to afford.

Ms. Dowling stated that seniors in effect lose money because all other costs of living continue to increase.

Also, step therapy results in destabilizing patients from accepted drug regimens into drugs that are not effective or beneficial.

Joan Lee, representing the Gray Panthers, stated that she was appearing to represent seniors and those who contact the Gray Panthers seeking assistance with medication access.

Ms. Lee stated that access to care is a problem. There needs to be both urgency and timeliness for patients to obtain prescription medicine, and it is important that there be smooth communication among those who should be partners in patients' care – the doctor, the insurance company and especially the pharmacist.

She encouraged the board to seek the best practices in the pharmacist community.

1. Coordination of the full array of meds a patient takes so that all meds that can be refilled are refilled at the same time. This would reduce multiple trips to the doctor and pharmacy for the caregivers, which is a needless waste of their time for repetitive and otherwise avoidable trips.
2. Smoother communication among patients, their doctors and pharmacists to adjust care, dosages, and medicines. Speed and coordinated communications

will offer a better time management for patients and their caregivers, and providers need to suggest best choices in medicines for patients.
3. Communication with patients should be done with a respectful, problem-solver attitude to patients.

As an example, she stated that one patient was required to get a power of attorney assigned to a caregiver in order for the caregiver to pick up the meds. The result: anguish by the patient and delay in the patient obtaining the medication.

The pharmacist is an extension of the medical care a patient receives and this care needs to be meticulously provided over the phone and over the counter to patients.

Adam Dorsey, California Health Advocates, stated that California Health Advocates provides assistance to patients with selecting and resolving problems with their Part D plans. They continue to see problems with the plans and believe patients do not have the information they need in a useful form upon which to select their plans on the basis of benefits.

Charles Phillips, M.D., emergency room physician, stated that he is concerned with the practice of pill splitting and the resultant crumbled residue of drug product in the bottom of pill containers. He stated the practice of pill splitting is a problem because pills do not split evenly, and patients get uneven doses of medicine.

Chairperson Goldenberg asked Dr. Phillips to provide information on this topic at a future board meeting.

Fred Mayer, RPh, MPH, Pharmacists Planning Service, Inc., made a number of suggestions to improve the patient care available through Plan D. Mr. Mayer stated that one problem is that there is no standard for pharmacy practice under the Medicare Modernization Act. There is no method to evaluate quality and access to pharmacy services.

Lack of standards also results in firms like Medco paying a $155 million fine to settle fraud/kick-back charges and illegal switching of drugs. Lack of data and transparency are key problems that need to be corrected so the plans can be evaluated. Failure to have this data available results in fraud and abuse by the PBMs/HMOs/ prescription drug plans and managed care organizations.

The CMS needs to be given oversight authority to control the prescription plans.

Additionally, Mr. Mayer stated that selection of drugs on a formulary can be a problem. For example plans may select a drug as the preferred drug, that should not be the preferred drug or even be available for sale. For example, Crestor has been placed on some Part D formularies as the preferred drug, but Crestor has been shown to have muscle-destroying side effects, Rhabdomylosis, and acute renal and kidney failure.

He stated that what was needed was evidence-based medicine, similar to what exists in Oregon or under the old MediCal program.

He also stated that the program lacks a way to get medically needed prescription drugs in a time manner, in a system like the TAR process under MediCal.

Mr. Mayer stated that pharmacies will fill 4 billion prescriptions in 2007. The 30-day supply system needs to be replaced with one that allows a 90-day supply for maintenance drugs. This will reduce the number of prescriptions by 50 percent, which will allow improved pharmacists care for all.

He suggested enactment of SB 840 for universal health care as a better alternative.

Chairperson Goldenberg stated that there has been a variety of testimony at this and prior meetings. Although many patients are now benefiting from Part D plans, there is still a group of patients who are frustrated with the benefit. Patient advocate groups are also frustrated in trying to obtain medicine and coverage for these patients. Pharmacies are spending time trying to aid patients, and are doing the work of the plans in helping patients select appropriate plans.

The plans need to be required to provide patient care and access to care timely.

Plans that participate in Part D should be required to agree to provide this care or else they cannot participate as providers.

Currently, there are 156 pages of instructions and components describing the 55 plans available in California and this is too complex. If some remedial changes are not made, patients will continue to become worse.

Motion: Chairperson Goldenberg/Andrea Zinder: establish a mechanism for California stakeholders to provide ideas on improving Part D to benefit patients.

The meeting was adjourned at 12:02 p.m.