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

Communication and Public Education Committee
Subcommittee on Medicare Drug Benefit Plans
Public Forum on Medicare Part D Plans

MEETING SUMMARY

Date: March 30, 2007

Location: Los Angeles International Airport
Samuel Greenberg Board Meeting Room
1 World Way
Los Angeles, California 90045

Board Members Present:
Bill Powers, Board President and Chairperson
Stan Goldenberg, RPh, Board Member
Clarence K. Hiura, PharmD, Board Member
D. Timothy Dazé, Board Member

Staff Present:
Virginia Herold, Executive Officer
Robert Ratcliff, Supervising Inspector
Karen Abbe, Public and Licensee Education Analyst

A. Call to Order and Introductions

Chairperson Powers called the meeting to order at 9:32 a.m.

Mr. Powers stated that this is the continuation of an open forum the board provided on February 1, 2007 on the Medicare Part D program. This is the 5th meeting in a series of meetings convened by the board since the Medicare Modernization Act's prescription drug plan benefit was rolled out. The board hosts these meetings so that those with unmet concerns with the program have an opportunity to voice their concerns and seek solutions. Hopefully these discussions have led to some improvement already.

Mr. Powers introduced Lucy Saldana, PharmD, a pharmacist with CMS Region 9, who participated via speakerphone. CMS Regional Administrator Jeff Flick became unable

to attend this meeting very recently, but agreed to join via telephone later in the afternoon.

B. Medicare Part D Implementation – Issues and Comments from Patient Advocates

Mr. Powers stated that the purpose of this forum is to continue the discussion among stakeholders and policy makers on issues impacting the quality of services provided to patients under the Medicare Modernization Act's Prescription Drug Plans for California patients. At the forum held on February 1, 2007 in San Diego, provider comments were predominant. At today's forum, he wanted advocates to have adequate time to state their concerns and ideas.

David Lipschutz introduced himself as Staff Attorney for California Health Advocates. He said he provides free and unbiased information to consumers about HICAP. He works with HICAP and speaks for them, saying what they cannot say and should not say. He identifies problems and troubleshoots to make the program better.

Mr. Lipschutz referenced an executive summary from the Center for Medicare Advocacy, Inc., dated January 16, 2007. He said the summary was an excellent resource, which outlines the issues surrounding the Medicare Part D Program after its first year, but today he wanted to focus on several broad issues.

- Medicare marketing and misconduct during sale of Medicare and Part D products

  People are being enrolled in Medicare Advantage and Part D plans that they either did not intend to enroll in, or they enroll in plans that are not right for them. The private fee-for-service programs are particularly problematic. Since the Act was passed, there has been a mushrooming in the numbers and types of products, notably in Medicare Advantage plans. There is not enough corresponding oversight of those plans or the agents and brokers offering the plans. There is difficulty in changing into more suitable plans once a patient realizes he/she would be better served in another plan. Medicare beneficiaries do not have sufficient knowledge to make choices among the plans. There is a fundamental misunderstanding among agents and brokers about how these plans work.

  Mr. Lipschutz stated that the system is ripe for abuse because high commissions are paid to agents when they enroll people in Medicare Advantage plans, higher than for stand-alone prescription plans. These high commissions result in "migration" where people sign up for Medicare Part D, then the agents try to enroll the same individuals in their more lucrative Medicare Advantage products.

  Private fee-for-service plans have proliferated, but they are also the least understood. People who are dual-eligible in Medicare and Medi-Cal are being

targeted for private fee-for-service plans, which sometimes results in those consumers losing their chosen providers who are not part of the coverage.

Mr. Lipschutz stated that oversight of agents and brokers has been lax. There is conduct that is questionable, and in some cases, outright misconduct is occurring. Agents are participating in practices like going door to door in senior resident facilities, and doing mass enrollment of 40 or more people at a time. He said that on the California Health Advocates Web site, they have an Issue Brief entitled "After the Goldrush: The Marketing of Medicare Advantage and Part D Plans, Regulatory Oversight of Insurance Companies and Agents Inadequate to Protect People with Medicare." The brief reveals misconduct by agents that negatively impacts dual-eligible beneficiaries.

- Limited open Enrollment period, including open enrollment that starts Sunday April 1, 2007

  Mr. Lipschutz stated that there is one choice per election period to get in or out of a plan, with restrictions. There's a limited open enrollment period set to go into effect on April 1, 2007. During this period, beneficiaries can make a "one way" movement into a Medicare plan. There are potentially serious consequences. For example, if an individual enrolls in an HMO or PPO and has stand-alone prescription drug coverage, they will lose their stand-alone prescription drug coverage for the year.

- Disenrollment of beneficiaries by Sierra RX Plus

  Mr. Lipschutz stated that Sierra RX Plus provides brand name coverage in the gap (donut hole). Until just a few weeks ago, no Part D plan involuntarily disenrolled enrollees due to nonpayment of premiums. Suddenly there was a rise in involuntary disenrollments. Some people were disenrolled despite timely payments during a grace period to bring payments current. Sierra was kicking people out of their plans, and unwilling to let people back in to their plans even when payments were brought current. CMS ordered Sierra RX to reinstate their 90-day grace period during which enrollees can bring their premium payments up to date.

  Mr. Lipschutz stated that Sierra RX informed their investors that they were losing money on the prescription plan, and accused another company of steering their most costly patients to enroll in Sierra's plan.

- Heroic efforts made by pharmacists

  Some pharmacists have taken out lines of credit in order to provide prescription coverage to enrollees. Many pharmacists are still unaware of the WellPoint point-of-sale system for dual eligible people. It's a rough "safety net" for those not enrolled in a Part D plan, but all pharmacists do not use the system, and

some are refusing to use the system. CMS says they can't force pharmacists to use the system.

Mr. Lipschutz also stated that there are lags in data for the low-income subsidy. Some Part D enrollees can get assistance, reducing costs sometimes from $5 down to $1 for a co-pay. If the low-income subsidy beneficiary provides proof like a Medi-Cal card, some pharmacies are still refusing to apply the discount.

- Notices and/or posters at pharmacies

  CMS rules require either a poster or notice handed to patients saying they can ask their plan to cover a certain drug or share in the cost. Pharmacists either don't have the notices, or put the poster out of view of customers. Mr. Lipschutz and his organization are calling for a more uniformed standard so that beneficiaries will know that they can contact their plans to and ask for coverage of certain medications.

Mr. Goldenberg asked Mr. Lipschutz to give this presentation at the April 18, 2007 full board meeting. He believed the information would be enlightening.

Mr. Lipschutz said he will be out of town on that date, but can send another representative of California Health Advocates.

Mr. Goldenberg asked if he had knowledge of challenges for long-term care and home infusion patients.

Mr. Lipschutz responded yes, but heard of these problems less frequently.

Mr. Goldenberg said the "plan side and provider side" were present, and he encouraged Mr. Lipschutz to stay for the full meeting so he could provide suggestions to solving these problems.

Mr. Lipschutz stated he has made recommendations to CMS Region 9, but the CMS policy office in Baltimore needs to approve the recommendations. He proposed that agent commission fees should be "flat," but unfortunately there must be some incentive to sell Medicare Part D products verses Medicare Advantage plans. An equal commission fee structure is facing strong industry resistance.

Mr. Goldenberg said it appeared there was cooperation from Region 9 in general, but policy changes must come through Baltimore. He asked if there were an entity in California assisting in oversight of these plans, would it facilitate the ability of seniors to get benefits or provide additional protection?

Mr. Lipschutz replied that from a beneficiary standpoint, California state agencies are prohibited from regulating Part D plans. The Department of Insurance has oversight of agents, so maybe they can weed out bad agents for misconduct. In one case that he

was aware of though, although there were reams of evidence showing misconduct by an agent in one plan, the agent just went to work for another plan.

Mr. Goldenberg said he wanted to make a personal statement that the board has not been having these subcommittee meetings for enjoyment. We want to protect seniors, and the dual eligibles. And it is even more difficult for those patients who are institutionalized.

Mr. Lipschutz stated that in one case of marketing misconduct in a long-term care setting, an agent went to the home of a sister who was the conservator for her brother. The sister enrolled her brother in a plan, and it turned out that the long-term care facility her brother was in did not do business with that plan. Later, the sister had to undue the damage caused by enrolling her brother into the wrong plan.

Dr. Saldana said she appreciated David Lipschutz bringing these problems to light. She wanted to mention that Sierra RX, as of March 23, 2007, had reinstated beneficiaries that were disenrolled. She invited people to contact her to ensure that everyone who should be reinstated does get reinstated.

Mr. Powers asked if Region 9 can play a part in resolving these problems, and whether there is oversight by CMS.

Dr. Saldana stated that she's been working with David Lipschutz and other advocates regarding some of these problems. In terms of regulations, many of those issues are controlled out of their central office.

Mr. Powers asked if there were any other representatives from other consumer groups who wanted to speak. There were none.

C. Issues Involving Specialized Settings (e.g., Long-Term Care, Infusion Pharmacies)

Mr. Powers asked if there was anyone who wanted to make a presentation regarding specialized settings such as long-term care or infusion pharmacies.

Sherri Cherman, Chief Operating Officer of Modern Health, said Modern Health has retail pharmacies that find meds for patients with chronic conditions like HIV and other high out-of-pocket costs. They also serve skilled nursing facilities and infusion services at home. Ms. Cherman said that in long-term care, costs are shifting in Part D plans, and the pharmacies are left with the financial risk if they provide medication before it is approved. Modern Health ends up taking the financial risk. They either pay for the medication or the long-term facility pays.

Mr. Goldenberg added that state and federal laws for timely administration of medications means that if a doctor orders a drug on a stat basis, it must be given to the

patient within one hour, and the majority of medications must be given within four hours. The facility is placed in an environment of having to provide medication timely, and pharmacies have been taking it on the chin as far as cost. Facilities state that when they can't provide an expensive medicine, they'll send the patient back to the acute hospital setting which can mean a $3,000 a day environment just to get medicines in a timely manner. The board needs to shine a light on this problem so that people don't get hurt. When elderly patients are transferred between facilities, even just between rooms in a facility, it causes harm to the patient just because they are moved. Morbidity and mortality increase when patients have to be transferred, and we must protect these patients.

Ms. Cherman stated that Modern Health has been accepting the financial risk to aid patients in getting medicine more quickly, but they cannot continue taking this risk indefinitely. Additionally, securing approval for payment has required the addition of staff, just for this function.

Mr. Goldenberg stated there is minimum oversight of this government program. We must protect the most vulnerable frail and elderly, and other with significant diseases. People walking into pharmacies have more options than the most frail or sick patients.

Mr. Powers asked Dr. Saldana if CMS can offer responses as to how we can stop this elder abuse.

Dr. Saldana replied that if Mr. Powers meant that pharmacies are exposing themselves to financial risks in the current environment, she agrees with Sherri Cherman's assessment of the situation. She has heard that things have gotten better from pharmacies. While this is what she understands from the pharmacies that have contacted her, there are still problems. When pharmacists call her, she tries to connect them with the specific plan to get assistance. She agrees that issues need to be tweaked, but plans have been trying to address the problems.

Mr. Goldenberg stated that if there is improvement, he can't help but think about the situation starting at absurd, and now we're at unacceptable. He asked how we could prevent patients from being hurt.

Dr. Saldana replied that Region 9 has been passing these concerns to the central office during conference calls. She wishes there was an answer coming down the pipeline.

Mr. Powers asked if changes must be made in law by Congress.

Dr. Saldana replied that yes, Region 9 doesn't make laws, and you need to write to your congressman. Region 9 just puts the laws into effect.

Ms. Cherman stated that she believes the situation has actually gone from horrific to unacceptable. It has reached a plateau recently, with no improvement in the last six

months. It is very costly for pharmacists to continue to complain because it takes a lot of time on the phone to get through to someone who can help.

Mr. Goldenberg thanked everyone who spoke and who attended today.

Executive Officer Herold asked Ms. Cherman about the 3,000 patients they serve in skilled nursing, and how many of those patients had to be moved back into a care facility in order to get the medication coverage they needed.

Ms. Cherman estimated that over 100 patients with acute needs have had major disruptions to their care during the year, and had to be moved to a facility offering a higher level of care for medication coverage.

Mr. Goldenberg added that pharmacies can't continue to absorb costs, so that number of patients being transferred is going to grow.

Mr. Dazé stated that the economy is taking a hit in a lot of areas, and pharmacies may discontinue these carrying costs because they are responsible to shareholders. Publicly traded companies may not be able to continue to fill the prescriptions without payment.

Mr. Powers stated that long-term care costs government more than if they provided for this therapy at home.

Mr. Goldenberg emphasized the impact that the trauma of transfer causes to patients. There is a 25 percent mortality rate due to the transfers, not due to the underlying disease.

Mr. Powers invited the public to ask questions or give comments.

Eileen Goodis, from Walgreens, said that home infusion patients are staying in the hospital an extra one to four days because there's no prior authorization to continue the therapies at home. Plans require prior authorizations before authorizing medicines for patients who are sent home with the same therapy they received in a hospital. Ms. Goodis suggested that there be an automatic 10-day authorization to continue the medications upon discharge, to allow time for the plans to approve the ongoing therapy at home.

Ron Belville stated that he has worked in long-term care for a long time. He's been listening to agents and their marketing plans. He said information is not provided to help people make informed choices as to which plan would best fit their needs. He said people should not be steered towards certain plans due to financial incentives because other plans may be better suited for certain patients. He suggested that better information about the plans be provided.

Ira Halpern, President of Modern Health, stated that for 20 years, he has experienced that one size cannot fit all. Retail patients can be better served because they can walk away, but patients in facilities are different. One plan cannot work for all kinds of specialty needs. One mousetrap does not work for all mice, and different issues and different settings like long term care verses home care.

Michael Rigas, Senior Vice President, Crescent Healthcare, provided a presentation.

Dr. Rigas stated that pharmacies are absorbing financial costs to provide patient care. Part D does not provide adequate coverage for home infusion therapy. The result is patients have to stay in the hospital longer, or go into skilled nursing facilities, or pay large out of pocket amounts. The nuances between Medicare Parts B and D are problems for patients, providers and payers. Part D rules and exclusions are confusing to most patients, and changes to Part D rules result in higher co-pays to patients, less doughnut hole coverage, more restrictive formularies, and higher monthly premiums.

Dr. Rigas' outlined 12 suggested changes to correct the problems with Medicare Part D. Some of the suggested changes included reorganizing how Medicare Part B and Part D relate to each other in order to benefit patients, allowing Part D to pay an infusion per diem, relaxing home-bound regulations so that Part A nursing can pay for infusion nursing, controlling the number of plans available in a region, ensuring that authorizations are timely and accurately reflect patient's drug and disease state, and re-establishing the automatic 10-day authorization for drugs provided under Part A.

Dr. Rigas stated that there has been discussion on whether Crescent can continue offering Part D under the current rules.

Mr. Powers stated that a bill has been introduced federally to require a "report card" of Medicare Part D.

Mr. Goldenberg asked about the dispensing of vials. There are sterile compounding regulations, and out of state licensing regulations. Between those two regulations, vials are still being sent to patients who are supposed to admix their own. This should not be happening, but it is.

Ms. Herold clarified that anyone shipping drugs into California is required to be licensed by the Board of Pharmacy. If a product must be mixed and it is sent not mixed, it would be viewed as a prescription error. It's a quality of care issue.

Mr. Goldenberg stated that unless a patient complains that something wasn't mixed right, the board would not be aware there was a problem.

Mr. Powers thanked Dr. Rigas for his presentation. He asked if there were any other comments regarding specialized groups.

Molly Forest introduced herself as CEO and president of the Los Angeles Jewish Home. She stated that it is one of the largest nursing homes, and she can share the challenges that the Jewish Home has been experiencing.

Ms. Forest stated that while they are not the largest nursing home in California, they are the largest single source provider of welfare (Medi-Cal) recipients. She said that the Jewish Home operates community clinics and has their own medical group. They have several concerns.

The average age of their patients is 90. There are difficulties with the prescription drug benefit due to patient intolerances to the administration drug route and the drug that each patient would prefer. The paperwork is so cumbersome. Prior to part D, they spent $200,000 on medicines that welfare would not cover, but now it's $400,000 a year because their philosophy is to never put a patient in jeopardy.

Ms. Forest stated that they are concerned about formularies because of intestinal and absorption issues. Liquid vitamins are absorbed much better by the elderly. The Jewish Home provides these at their own cost because liquid vitamins are not covered. With the elderly, you must get them into the proper plan, then you get into formulary issues. She would like to see standards developed to address this.

California has a category called medically needy only (MNO). Those individuals are only allowed $20 per month for incidentals, which is easily eaten up by clothing, toothpaste, and over the counter medications, a level that has not been increased for years.

Mr. Powers stated that the Jewish Home sent a 93 year old recipient to testify to Governor Davis on the matter of MNOs. Unfortunately, Governor Davis was recalled, and Governor Schwarzenegger has not addressed MNOs. There are only about 200,000 MNO beneficiaries.

Mr. Dazé asked if the Jewish Home had approached the Assembly, which is controlled by the Democratic Party, in order to introduce legislation.

Ms. Forest stated that they need the Board of Pharmacy to aid in getting legislation introduced.

Mr. Goldenberg asked about getting authorizations for nonformulary drugs. For example, if there are 800 patients and only four physicians, is there a number as to how many of these authorizations they're faced with.

Ms. Forest replied that there are about 100 authorization requests per week for 800 residents.

Mr. Goldenberg stated that long-term care physicians constantly move from one institution to another during the day, and they can receive sometimes 100-500 faxes per day. Prior to Part D, it was around 30 faxes per day.

D. Comments from Part D Plan Providers

Mr. Goldenberg invited other plan providers to come forward with their comments.

John Jones, United Health Care, stated that he would talk in general terms because they have a large plan with about 6,000,000 enrollees in Medicare. He said that they've made improvements, but Part D was never designed for long-term care or infusion care. He encouraged Lucy Saldana to chime in.

Dr. Saldana stated that CMS has had a lot to deal with during a short time period. Medicare and Medicaid are safety net programs, so money won't be thrown at the problems because there's a preservation of public dollars. The programs must run efficiently and economically to make people happy. They are working with Crescent and other providers to make things work better.

Richard Katz, CEO of Modern Health, said that he is beginning to see consolidation within third party plans. The future of pharmacies and taking care of seniors is going to be more difficult. Mr. Katz asked that the board protect the rights of patients in California, but he doesn't know what the recommendations should be. He sees the hurdles getting worse, and economic constraints getting tougher. He wants the board to voice what we can accept and cannot accept. He turns to the board as the leader to help solve these problems.

Jacqueline Ejuwa, Blue Shield of California, stated that she has worked in pharmacies in long-term care. She said she echoed the things that John Jones mentioned. The challenges of what's covered under Part B and Part D and prior authorizations are difficult, as well as an understanding of levels of care and patients moving in between and back and forth. She stated that Blue Shield will "override" lack of a prior authorization in order to ensure patients receive the same therapy they received in licensed facilities to provide emergency amounts of medications to patients when they are discharged.

Mr. Goldenberg asked if a resident comes to a nursing home on a drug therapy, is that a continuation of therapy and is the drug covered?

Ms. Ejuwa replied that yes, it is for 30 days, and most providers know that. For home infusion, she's not sure.

Ms. Herold asked whether they can get an override without authorization from the plan.

Ms. Ejuwa replied that yes, by following certain processes. They call the third party claims processor for a patient that needs a transition supply of medicine and is already stable on that same medication. They can call a claims processor 24 hours a day, 7 days a week. It usually takes about 5-10 minutes, but no longer than 15 minutes. After receiving the override code, they can provide the transition supply of medicine to the patient.

Mr. Goldenberg asked CMS if there was a way to get this encouraging news out to other plans, and whether the board can put it in our publication. He also asked whether CMS had other answers.

Dr. Saldana replied that she was encouraged that processes are in place to get the medications to patients. She wants to allow market forces to hear how this plan operates, and she has no problem if we put it in the board's newsletter.

Mr. Goldenberg stated that the long-term community has an open formulary for long-term care patients. Because they're responsible for the whole patient, they don't want patients getting expensive care in other settings unnecessarily.

Mr. Powers said there should be a system where information like this does not have to be provided by rumor.

Dr. Saldana stated that on the Medicare.gov Web site, they have performance standards, overviews about customer service, complaints, appeals, and so on. She noted that it's only a start, but the information is being posted on the web. Family members can get information by looking on the web at the statistics. As more data is provided, people should look at it again.

Mr. Goldenberg stated that with all due respect, a 90 year old patient will likely have a 70 year old son or daughter. The system of communication should be familiar to the clients. The Web site may not be feasible because people will have to fish through the technicalities that he himself finds hard to follow.

Dr. Saldana replied that he should go on Web site, highlight the good plans, and put them in the newsletter, but without promoting certain plans.

E. Open Discussion and Problem Solving on General Items of Interest

Dr. Hiura asked Ms. Ejuwa to clarify which plan she was with, and to share what she knows about authorizations for transition supplies.

Ms. Ejuwa stated that she manages the drug authorization process for Blue Shield of California, and that transition supplies are for patients that are already in care. She suggests that other plans should change their policies to reflect the needs of patients that are already in care.

Mr. Goldenberg stated that having a regulation without oversight is not good.

Ms. Ejuwa stated that Medicare Part D is so complex that information gets lost in translation. Her plan reminds people on the phone that these are patients that are already on therapy, so they just need a transition of that therapy.

Dr. Hiura shared a personal story of his mother in who is currently living in the Jewish Home on 4th and Boyle. His mother is 97 years old, is indigent, and in a wheelchair. He supplements her with money to buy over the counter medications. She is dual eligible. Dr. Hiura stated that fundraisers also chip in to help fill the gap for these patients.

Magda Gabali, Department of Health Services, stated that she hasn't looked at the CMS Web site for a while, and wanted to know if there are links to specific plans so that people can ask questions. She recalled the Web site only listed plans, but with no direct link for consumers to get to the plans' Web sites. She stated that it would be more helpful to provide links to the specific plans, and not just a list.

An unknown person from CMS spoke via speakerphone stating that getting transition authorization can be just as time consuming. Allowing a co-indicator would help.

Ms. Ejuwa said that she must call first, then do a computer override. That saves one to two days, but still costs around 15 minutes on the phone.

Mr. Jones said that Health Net implemented a code to allow for transitional authorization, and they broadcast that information to pharmacies.

Mr. Lipschutz said he wanted to speak to an earlier issue about steering people towards or away from any particular plans. He said HICAP is not allowed to steer people towards or away from particular plans. He stated that the CMS Web site is very confusing regarding prior authorization. You can't ask frail and ill people to navigate a 50-page Medicare Web site.

Mr. Powers thanked everyone for sharing their concerns and proposed solutions. He said these meetings have been held to give people a platform. Now we should go beyond, and publicize those concerns and possible solutions. We will also be looking to state and federal legislation, and will bring these ideas to the full board to see if we can expand. We must impress upon CMS and Congress to change these flaws in the program.

F. Adjournment

There being no additional business, Chairperson Powers adjourned the meeting at 12:05 p.m.