**Meeting of the Advisory Panel on Medicare Education (APME)**
**Centers for Medicare & Medicaid Services (CMS)**
**January 26, 2006**
**Wyndham City Center Hotel**
**1143 New Hampshire Avenue, N.W., Washington, D.C.**

**Agenda**
***Centers for Medicare & Medicaid Services Update***
***Listening Session with CMS Leadership***
***New Medicare Prescription Drug Benefit Plans Overview***
***Campaign Activities***
***Education and Outreach Strategies***

**Location:**

The meeting was held at the City Center Hotel, 1143 New Hampshire Avenue, N.W., Washington, D.C. 20036.

**Federal Register Announcement:**

The meeting was announced in the December 23, 2005 *Federal Register* (Volume 70, Number 246, Pages 76317-76318) (Attachment A).

**Panel Members Present:**
Katherine Metzger, Chair, APME; Director, Medicare and Medicaid Programs, Fallon Community Health Plan
Dr. Jane Delgado, President and Chief Executive Officer, National Alliance for Hispanic Health
Clayton Fong, President and Chief Executive Officer, National Asian Pacific Center on Aging
Thomas Hall, Chairman/Chief Executive Officer, Cardio-Kinetics, Inc.
David Knutson, Director, Health System Studies, Park Nicollet Institute for Research and Education
David Lansky, Director, Health Program, Markle Foundation
Daniel Lyons, Senior Vice President, Government Programs, Independence Blue Cross
Frank McArdle, Manager, Research Office, Hewitt Associates
Traci McClellan, National Indian Council on Aging
Dr. Keith Mueller, Professor and Section Head, Rural Health Policy Research Institute, University of Nebraska Medical Center
Lee Partridge, Senior Health Policy Advisor, National Partnership for Women and Families
Rebecca P. Snead, Administrative Manager, National Council of State Pharmacy Association Executives
Catherine Valenti, Chairperson and Chief Executive Officer, Caring Voice Coalition

**Panel Members Absent:**
Dr. Drew Altman, President and Chief Executive Officer, Henry J. Kaiser Family Foundation
The Honorable Bobby Jindal, United States House of Representatives
Dr. Frank Luntz, President and Chief Executive Officer, Luntz Research Companies
Dr. Marlon Priest, Professor of Emergency Medicine, University of Alabama at Birmingham

Susan O. Raetzman, Associate Director, Health Team, Public Policy Institute, AARP
Marvin Tuttle, Jr., CAE, Financial Planning Association
Grant Wedner, Cosmix Corporation

**Designated Federal Official:**
Lynne G. Johnson, Center for Beneficiary Choices (CBC), Centers for Medicare & Medicaid Services

**Others:**
A sign-in sheet listing other attendees is incorporated as Attachment B.

**Welcome and Open Meeting**
**Lynne Johnson, Centers for Medicare & Medicaid Services (CMS)**

Ms. Johnson, the Designated Federal Official for APME, called the meeting to order at 9:00 a.m. She turned the meeting over to the APME Chair, Katherine Metzger.

**Introduction of Members/Review of Previous Full Panel Meeting**
Katherine Metzger, Chairperson, APME

Ms. Metzger welcomed the panel members. She introduced two new members: Traci McClellan, Executive Director of the National Indian Council on Aging, in Albuquerque, New Mexico; and Dr. Frank McArdle, Manager of the Hewitt Research Office of Hewitt Associates, in Washington, D.C. She stated that a third new panel member, Marvin Tuttle, Executive Director and Chief Executive Officer of the Financial Planning Association, in Denver, Colorado, was unable to attend. She then asked the panel members to introduce themselves. She reviewed highlights of the previous meeting that included (Attachment C):

- An update by CMS Administrator, Dr. Mark McClellan, on the number of drug plans across the country, premium pricing, and the training of counselors who assist beneficiaries with choosing a drug plan;
- An update on drug plan marketing guidelines;
- An update on fraud and abuse oversight;
- An update on CMS' programs to improve public awareness of the new drug plan benefit; and
- An overview of the Medicare Prescription Drug Plan Cost Estimator and Formulary Finder.

Ms. Metzger asked that the following changes be made to the September 27, 2005, APME meeting minutes: 1) Change the word "approving" to "providing" near the bottom of page 4 so that the sentence reads, "CMS is also approving their materials;" and 2) Change the sentence, "Fallon Community Health Plan serves about 32,000" to "Fallon Community Health Plan serves about 32,000 Medicare beneficiaries." She introduced Abby L. Block, the newly appointed Director of CMS' Center for Beneficiary Choices.

**Centers for Medicare & Medicaid Services Update – Abby L. Block, Director, Center for Beneficiary Choices (CBC), CMS**

Ms. Block thanked the members for taking time to participate on the panel. She stated that enrollment in the new prescription drug benefit was going very well, and that as of January 17, nearly 24 million seniors and people with disabilities had prescription drug coverage. Ms. Block stated that CMS was carefully reviewing processes and systems to resolve systems issues that have impeded the enrollment process, especially for dual eligibles.

Ms. Block stated that during this transition period, some states have decided to temporarily pay for dual-eligible and low-income subsidy eligible beneficiaries' prescription drugs. She explained that the agency is working to expedite communications between pharmacists and insurers to allow overrides that will permit beneficiaries to leave their pharmacies with the medications they need. There is an extensive casework effort in place to help beneficiaries get their medications expeditiously.

Discussion

Member Comment - Clayton Fong stated that his organization found that for at least 60 percent of the people the organization serves, one drug was not covered by the drug plan to which they were randomly assigned. He also stated that his organization had assisted Asian-American beneficiaries in completing LIS applications and submitted them to the Social Security Administration (SSA) last summer. To date, three out of four of these beneficiaries have not received a reply from SSA.

CMS Response - Ms. Block explained that beneficiaries have access to every medically necessary drug under the new drug benefit. It may mean that the beneficiary will have to change to a drug that is equivalent to what they have been prescribed. She also stated that the transition period gives beneficiaries time to switch to a comparable equivalent drug if appropriate, or for physicians to ask for an exception if the beneficiary must be on the specific drug they are currently taking. She asked for the panel's help and advice on this issue since the agency is looking at the transition policy for next year and wants to learn from this year's experiences. (CMS is working with SSA to resolve issues with the LIS applicants.)

Member Comment - Dr. Daniel Lyons suggested that the panel form a subcommittee to provide recommendations on issues CMS is encountering since implementing the new prescription drug coverage.

Member Comment - Rebecca Snead stated that the 30-day transition supply of prescription drugs is insufficient to allow for the changeover. There is reluctance on the part of many physicians to change a drug regimen without first seeing the patient. In many cases, the patient cannot get an appointment immediately.

Member Comment - Dr. Frank McArdle recommended that search results using the Formulary Finder tool reflect the broad formulary versus the short formulary, because some generic equivalents are not showing up.

CMS Response - Ms. Block stated that generic equivalents could be found by conducting a search for the lowest cost drugs.

Member Comment – Dr. Jane Delgado reminded CMS of the importance of Medicare preventive benefits, particularly with regard to the "Welcome to Medicare Physical" examination offered to new beneficiaries. She asked how many people had signed up for the exam. In addition, she wanted to know what CMS is doing for outreach and education in other areas of prevention such as diabetes, heart disease, and smoking cessation. (CMS will address these issues with the panel at a future meeting.)

Member Comment - Traci McClellan stated that the inability of tribes to piggyback on the Indian Health Service's Prescription Drug Plan contracts has delayed the ability of dual eligibles in this population to be switched to a plan that is covered by the tribe. She also stated that sufficient training has not reached grassroots providers such as benefits coordinators and community health representatives.

**Prescription Drug Plan Update: Pharmacy Issues – Larry Kocot, Senior Advisor to the Administrator, CMS (Attachment D)**

Mr. Kocot explained that the task in launching the new drug benefit nationally required the integration of hundreds of plans, hundreds of systems, scores of different data bases, thousands of providers, and millions of beneficiaries [with long-term care, low-income subsidy and dual-eligibles all in one]. Plans have been extremely responsive in enhancing their customer service, but were still working on training newly hired customer service representatives and addressing language barriers.

Mr. Kocot added that CMS is doing a number of things to support both pharmacies and pharmacists such as conducting daily conference calls with pharmacists, pharmacies, and pharmacy associations to discuss issues, sending out frequent Medicare updates, and enhancing the agency's customer service number for pharmacists. CMS also developed the E1 system, designed to give pharmacists billing information needed to fill prescriptions. He stated that CMS has collaborated with a number of organizations, such as the National Council of State Pharmacy Association Executives and National Community Pharmacy Association in educating pharmacists about the program.

Discussion

Member Question – Lee Partridge asked if the plans were required to have a Drug Utilization Review system (DUR), a system that stores information on prescription drugs someone is taking to avoid inappropriate interactions.

CMS Response – Mr. Kocot explained that all plans have a DUR functionality as part of their contractual agreements with CMS.

Member Comment - Dr. David Lansky suggested that CMS look to the panel for recommendations on quality measures. Dr. Lansky asked what data is being captured and how will it be analyzed and reprocessed to permit beneficiaries to evaluate the performance of the drug plans.

CMS Response - Ms. Block explained that the data that was currently being captured would address customer service types of measures. (The panel will address quality measures at a future meeting.)

Member Comment - Mr. Fong asked if CMS thought about developing tools to help pharmacists assist beneficiaries who do not speak their language.

CMS Response - Ms. McMullan explained that CMS efforts have been directed to counselors because getting information into the hands of people who deal with beneficiaries with limited English proficiency is much more effective than us trying to figure out how to do that. She also stated that CMS was willing to work with Mr. Fong on this issue.

**Prescription Drug Plan Update: Employer Issues – Mark Hamelburg, Director, Employer Policy and Operations Group, CMS (Attachment E)**

Mr. Hamelburg noted that CMS is partnering with employers, unions, retiree organizations, and state health insurance programs to disseminate the message about the impact of the Medicare Modernization Act on Medicare coverage, including the new drug benefit. The goal is to give retirees enough information to make an informed decision about enrolling in a plan. In some cases, beneficiaries would benefit by staying in their existing plan if it gives them broader drug coverage at an equal or lower price. Retirees are encouraged to take their time when making a decision.

Employers and unions are required by law to provide creditable coverage notices to their employees or members to whom they are providing prescription drug coverage. Employers and Unions should go beyond what is legally required and provide additional information so that beneficiaries will understand what they need to do, what they can do, and what they cannot do in light of this new drug benefit. CMS has been conducting conference calls, giving speeches, and publishing printed materials explaining the new benefit. CMS relies upon information intermediaries to communicate and distribute messages to stakeholders and beneficiaries.

Discussion

Member Comment - Ms. Metzger suggested that in partnering, CMS seek input from some of the smaller businesses or from plans that have had interactions with smaller businesses. She stated that they were not well informed, did not understand creditable coverage, and did not know what they needed to do.

CMS Response - Mr. Hamelburg explained that most retirees are in larger plans and that CMS may consider targeting smaller plans as part of future outreach efforts.

Member Comment – In looking at the charge of the panel, Dr. Delgado suggested that the panel not just focus on what is going on now, but focus on providing guidance and advice on future outreach efforts as the agency moves forward. She suggested that the panel address the issue of prevention.

Member Comment - Dr. Lyons suggested that it might be helpful to review data on the choices employer groups and unions made in 2005. He stated that he had found that a surprisingly large number of employers, unions, and other groups supported Part D versus taking the subsidy.

CMS Response - Mr. Hamelburg noted that the majority of retirees are enrolled in retiree subsidy plans. Recent data showed that at least 6.4 million retirees were enrolled in retiree plans and recent estimates show that approximately 1 million retirees had Part D type employer coverage.

Member Comment - Dr. Lansky stated that the panel should capture current experience and then look forward. He suggested that the panel develop a mechanism to evaluate the quality of choices that beneficiaries and their sponsors are making.

**Break**

**Long-term Care Prescription Drug Plan Issues – Jeffrey Kelman, M.D., Chief Medical Officer, CBC, CMS**

Dr. Kelman explained that there are differences as to how community-based beneficiaries receive their prescription drugs compared to the institutional population. Community-based populations get their drugs from point-of-sale pharmacies and mail order. Institutionalized beneficiaries must receive their medications from a fixed location. The beneficiaries in nursing homes are not likely to have the same cognitive, social, and financial support systems or characteristics as community-based beneficiaries to navigate through a complicated benefit. There are certain drugs that are treated differently in a community-based than in a long-term care environment. This issue centers on the Part D versus Part B issue. In addition, institutions, particularly nursing homes, have a network of established long-term care pharmacies serving a particular region.

Dr. Kelman stated that CMS is working with the following groups on outreach and education efforts: American Association of Health Services; American Health Care Association; Assisted Living Federation; National Council on Assisted Living; American Medical Directors Association; National Association for State Mental Health Directors; Alliance for Nursing Home Reform; and National Association for State Development Disability Directors. CMS also sends out information to nursing homes through the Minimum Data Set system.

Discussion

Member Question - Dr. Delgado asked if there were data on the experiences of people whose drugs are not covered under MMA, specifically in the area of mental health, where it is known from the National Institute of Aging that there is a real nexus between older adults and mental health issues.

CMS Response - Dr. Kelman stated that in a survey done both by CMS and by the American Psychiatric Institute, 49 out of 50 state Medicaid offices have decided to pay for the benzodiazepines and the barbiturates for this group since the drugs are excluded.

Member Comment - Dr. Delgado stated that CMS' data only includes the people who are served by the program. There are some people who are not served, and there is no data on that population.

CMS Response - Dr. Kelman acknowledged Dr. Delgado's comment.

**Lunch Break**

**Medicare Outreach and Education Campaign Update – Kathleen Harrington, Director, Office of External Affairs, CMS**

Ms. Harrington stated that enrollment was going well and that credit should be given to all of the partners who have worked so closely with CMS on grassroots outreach and education. She noted that there were 3 Mobile Office Buses working across the country, participating in enrollment events in communities with volunteers from SHIPs and advocacy groups. She acknowledged the grass roots efforts being done by Dr. Jane Delgado (National Alliance for Hispanic Health) and Clayton Fong (National Asian Pacific Center on Aging). Ms. Harrington asked Mr. Fong to comment on what his organization was experiencing.

Discussion

Member Comment - Mr. Fong stated he had already discussed the problems that dual eligibles were experiencing but wanted to note that besides those problems, things were going quite well for the population that his organization serves.

CMS Response - Ms. Harrington explained that one of CMS' main systems tactics included giving the plans CMS' complete file of dual eligibles and beneficiaries qualifying for low-income subsidy so the plans can crosswalk the two sources of data. This effort is proving very effective. In addition, there has been positive feedback on the E1 system.

Ms. Harrington went on to brief the panel on the outreach and education campaign efforts. The Faith-Based Campaign in combination with the African-American Campaign is continuing to conduct outreach and education at a rapid pace. The Reverend Jesse Jackson asked for training for 1,000 of the ministers that he leads. Michele Tennery, who manages most of the campaigns, added that CMS has been partnering with the National Baptist Convention, the Progressive Baptist Convention, the Church of God in Christ, and major African-American civic organizations such as the National Association for the Advancement of Colored People, on outreach and education efforts. Ms. Harrington also highlighted the work that CMS is doing with specific disease groups such as HIV/AIDS, disability groups, and mental health organizations.

Discussion

Member Comment - Ms. McClellan stated that her organization, the National Indian Council on Aging, was able to get many of the Indian elders to visit a clinic, but clinic staff lack the tools necessary to switch beneficiaries over to different plans. She asked if CMS could provide some targeted training nationally for the Indian Health Service, tribal and urban, and clinic staff, on

how to handle health plan switches and other tasks related to implementing the new drug benefit in the Native American community.

CMS Response - Ms. Harrington explained that there is a provider tool kit available. Copies can be distributed to providers, and the toolkit is available for download on CMS' web site. She stated that it would be beneficial to hold more open-door forums with providers, to carry out more work on the ground with providers, and to carry out additional work with the chief medical officers in the plans, who could be communicating together.

Member Question - Dr. Delgado asked about CMS plans for 2008 and other issues CMS would address.

CMS Response - Ms. Harrington stated that CMS would address prevention, quality of care, and integrating the prescription drug benefit.

Member Comment - Ms. McClellan suggested that there should be a prescription drug plan primer on how to deal with issues specific to the tribes.

CMS Response - Ms. McMullan stated that this type of primer would be useful.

Member Comment - Ms. Snead suggested that in dealing with issues regarding the dual population, from a pharmacist's perspective, it would be helpful if CMS put a unique identifier on the beneficiary's Medicare card that would alert the pharmacist that this is a dual-eligible beneficiary.

**Public Comment**

There were no public comments.

**Listening Session with CMS Leadership - Mark McClellan, M.D., Ph.D., CMS Administrator**

Dr. McClellan noted the successes in the implementation of the drug benefit with millions of prescriptions being filled daily. This includes beneficiaries who are dual eligibles and who have signed up for coverage on their own. He explained that CMS has been focused on difficulties some dual-eligible beneficiaries have experienced during this transition--those who switched plans, but whose data did not immediately catch up with them, and those affected by problems relating to the transfer of data between different parts of the Medicare data systems and CMS systems. He explained that both of these groups are a small fraction of the overall population of dual-eligible beneficiaries; however, getting their drugs to them when they need them is crucial. Dr. McClellan described the systems in place to assist with these problems. These tools include the E1 system and a 24/7 toll-free pharmacist helpline used to expedite approval of drug coverage. Dr. McClellan stated that CMS is also working with state governments; 20 of which have activated their Medicaid billing systems to help in cases where pharmacists were having difficulty accessing prescription drug claims. CMS continues to reach out to beneficiaries who have signed up on their own for the new drug benefit.

Dr. McClellan stated that more information on quality and cost of care will be available during 2006. CMS is expanding tools that will be made available on the Internet to beneficiaries to help them get the care that they want. Hospital quality information is being expanded to include hospital surveys of beneficiary satisfaction and information on outcomes of post-surgical care as part of CMS' overall efforts on quality improvement. Dr. McClellan also stated that the Deficit Reduction Act pending before Congress will boost the agency's ability to help the states implement reforms in their long-term care programs by giving people with disabilities more control over how they will receive their services.

Discussion

Member Comment - Ms. Snead stated that what is needed now that Medicare is paying for prescription drugs is a "Welcome to Medicare" drug review. This will not just target prescription drugs alone but all medications received at the point of sale.

CMS Response - Dr. McClellan stated that he would like to see CMS do more work towards a demonstration program around medication therapy management and the development of more consensus measures around quality of pharmacy care.

Member Comment - Dr. Lyons stated that in looking ahead, CMS and the panel should develop strategies to effectively enroll the last 15 million beneficiaries into a drug plan.

CMS Response - Dr. McClellan stated that as CMS gets more enrollment information out, there would be some more evidence-based approaches to reach that group.

CMS Comment - Dr. Frank McArdle gave positive remarks on CMS' ability to integrate Part A experience and outcomes with Part B and Part D. He asked how CMS would use the data and disseminate it to outsiders.

CMS Response - Dr. McClellan explained that CMS had released a framework last year on the use of Part D data for learning more about what works, what does not work, evaluating potential medications, and finding out whether certain approaches that are more medication intensive can help prevent costs on the Part A and B sides. CMS is already using some of the Part B data for studies. CMS has collaborated with the Food and Drug Administration in a couple of areas where there was concern about the potential side effects of drugs and is determining if there is a relationship to Part B medication use. Part D data will be part of this overall approach. It may take some time before sufficient information is collected to be meaningful.

**Next Steps – APME Chair Katherine Metzger**

The panel made the following suggestions:

- Convene a subgroup to address transitioning under Part D issues and next steps. Clayton Fong, David Knutson, Traci McClellan, Dr. Keith Mueller, and Rebecca Snead volunteered to participate with Dr. Daniel Lyons chairing the subcommittee;

- Discuss prevention and the Welcome to Medicare physical;

- Address what initiatives CMS is planning in 2008 and be proactive in addressing those issues:
- Address quality of care;
- Discuss Special Needs Plans;
- Discuss the effectiveness of outreach and education and enrollment for the Low Income Subsidy group; and
- Discuss making use of the data that will emerge from the implementation of the Part D benefit.

**Adjournment**
Ms. Johnson officially adjourned the meeting at 3:30 p.m.

Prepared by:
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Approved by:
Katherine Metzger, Chairperson
Advisory Panel on Medicare Education

## Attachments

**A.** *Federal Register* (December 23, 2005, Volume 70, Number 246, Pages 76317-76318)
**B.** Sign-in Sheet
**C.** September 27, 2005 APME Meeting Minutes
**D.** *Prescription Drug Plan Update: Pharmacy Issues*, CMS
**E.** *Prescription Drug Plan Update: Employer Issues*, CMS