Testimony

Presented to the:

Senate Special Committee on Aging

March 3, 2005

Presented by:
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Seniors and People with Disabilities

Summary of Testimony
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Although the Medicare Modernization Act offers a great opportunity for many Oregonians, Oregon continues to have serious concerns with implementation and recommends the following important changes:

- The current timeframe for the initial enrollment process is too short, increasing the potential for unintended, unsafe and harmful consequences as Medicare/Medicaid dual eligibles transition into the Part D benefit. The timeframe should be extended to allow for a phased-in approach.
- The current regulation that requires Part D plans to have a transition plan for beneficiaries entering their plan needs specific details that will ensure that a fairly small subset of the Medicare/Medicaid population will not be harmed and costs shifted to states.
- People in Home and Community Based Waivered services need the same benefits and protections as those in nursing facilities and other institutions.
- States need to be relieved of the burden of developing a parallel process to the Social Security Administration to determine eligibility for the low-income subsidy.
- Access to necessary services supplied by Long Term Care pharmacies to a variety of facilities and institutions needs to be strengthened.
- States need access to individual specific information on medication supplied to Medicare/Medicaid dual eligible, without cost, in order to ensure quality, coordinated care.

March 3, 2005

Senate Special Committee on Aging:

My name is Tina Kitchin, M.D. I am the Medical Director for the Oregon Department of Human Services, Seniors and People with Disabilities. The Department of Human Services is the designated State Medicaid Agency, the State Unit on Aging, and the State Mental Health Authority. The Department administers five different Home and Community-based waiver programs and has responsibility for regulating all long-term care services in Oregon.

The Medicare Modernization Act offers a great opportunity for Oregonians, but comes with serious concerns. Oregon is very appreciative of the hours of dedication required by members of Congress and their staff to develop and pass this historic legislation. Approximately 129,000 Oregonians who currently have no drug coverage will soon have access to medications that will allow them to live longer, healthier lives. The U.S. Congress has addressed a critical health care issue for seniors and people with disabilities.

The Centers for Medicare and Medicaid staff's dedication and commitment have been impressive. Working within very tight deadlines, they have consistently produced professional, thoughtful products. We would like to thank them for their cooperative and open approach to this entire endeavor. They have sought the States', advocates', and providers' input at all steps. They have carefully weighed the multitude of interests, some of which were competing, and provided considered responses. The final regulations significantly strengthened access to Long Term Care pharmacies, strengthened beneficiary protections in appeals and grievances, and strengthened protections in the formulary design. Nevertheless, although progress and effort have been substantial, Oregon continues to have significant concerns that, without additional important safeguards, some vulnerable Oregonians may suffer serious harm, albeit unintentional.

Initial Enrollment Period.

The initial enrollment period will be a momentous programmatic change that, under the current rules, must occur in a very compressed time frame. Over 500,000 Oregonians will have to choose a plan, taking into account the

formularies, network of pharmacies, premiums and cost sharing, and enhanced benefits. The beneficiary must then compare their current medications to their new formulary, review their new network of pharmacies and make the necessary changes prior to receiving this benefit. Because Oregon does not currently allow pharmacists to make therapeutic substitutions, this will involve physicians having to write new prescriptions. Compounding these challenges is the fact the limited enrollment period overlaps the major winter holidays.

The problems presented by the limited timeframe are even more acute for beneficiaries who are dually Medicare and Medicaid eligible. Although they will be auto-enrolled in the available drug plans as soon as they are available to protect them from total loss of medication coverage, because the auto-enrollment process is completely random, the process will maximize the chances that a beneficiary is enrolled in a plan that does not meet their needs. The average Oregon dual eligible has ten to twelve medications. It is highly unlikely that all beneficiaries will be auto-enrolled in plans where the formulary completely matches their current medication profile and their pharmacy of choice.

Experience with the drug discount cards has highlighted the fact that most Medicare beneficiaries are not comfortable with the Internet and using 1-800 Medicare for enrollment. This is especially true for Medicare/Medicaid beneficiaries. A higher percentage have cognitive impairments, ranging from developmental disabilities and psychiatric illnesses to dementia, which not only make these choices almost impossible, but also make these tools irrelevant. The reality is that many individuals in this population will need the assistance of someone else to make these life-impacting decisions. For those without active family or friends, the responsibility for this assistance is likely to fall on Area Agencies on Aging, State Medicaid offices, Community Mental Health Programs and providers of Home and Community-based waiver services or institutions; all of which have other full time responsibilities.

Although additional funding was provided, CMS is relying on contractors in each state, Senior Health Information Programs (in Oregon called SHIBA, Senior Health Insurance Benefits Assistance), to educate Medicare beneficiaries in their choices and to assist them in the enrollment process. Oregon has a total of two staff for this program in the entire state. Those staff

rely on a network of approximately 200 volunteers to provide the actual assistance. Already the volunteers report having been overwhelmed by the drug discount cards. Hence the state has very strong concerns about the system's ability, during the allotted time frame, to handle the 50,000 Oregon dual Medicare/Medicaid beneficiaries, in addition to the over 500,000 general beneficiary population who may also seek assistance.

The task of ensuring that dual Medicare/Medicaid beneficiaries are successfully transitioned into the Medicare drug benefit within the statutory timeframes becomes a task similar to that facing Sisyphus from Greek mythology. Unfortunately, if this process does not go smoothly, Medicare beneficiaries will be harmed, resulting in unnecessary hospitalizations, visits to emergency rooms, and potentially incarceration and homelessness for those with significant mental illnesses.

In the early 1990s, Oregon successfully transitioned Medicaid eligible individuals who were categorically eligible as aged, blind or disabled into mandatory managed care. The primary lesson Oregon learned from that experience was that in order for a major transition project to go smoothly, it must be rolled out over a period of time; smooth transition cannot occur overnight.

<u>Recommended Solutions:</u>

1. Regulatory. CMS should require the Prescription Drug Plans to cover current medications at current pharmacies for the dual eligibles for at least six months. This will allow those assisting seniors and people with disabilities with enrollment to have the entire fall enrollment period plus an additional six months to ensure that people are in appropriate plans, the prescriptions match their chosen formulary. It will also allow long term care facilities and homes to establish critical business relationships with the appropriate pharmacies.
2. Statutory. A better solution would be to allow a full year for the roll out for individuals who are dually eligible. States would need to draw down federal match during this time, but only until the person is enrolled in a Part D Plan. This would allow states to develop plans and transition different groups over the year into the Medicare

benefit. At any one time, only Medicaid or Medicare would be responsible for the medication costs, never both.

Grandfathering or Transition

Current CMS regulations require the new Part D plans to have a transition plan for beneficiaries entering their plan. This regulation has neither detail nor specifics. In addition, CMS has indicated that they will use current Pharmacy Benefit Managers' transition plans as a standard in evaluating the new Part D plans' transition safeguards.

Oregon is concerned that not all beneficiaries should be forced to transition to new medications. This is a very vulnerable population with many conditions that are not common in general populations. Individuals who are stable on particular antipsychotics may never be safe to transition. If forced to switch medication and they decompensate, there are consequences not only to the individual, but to the community. There are also other drug classes where individuals should not be required to transition off their current medications, such as those difficult-to-control seizures or AIDS, among others.

Recommended Solution:

1. Regulatory. CMS should require that Part D plans allow certain individuals to remain on certain classes of medications without needing to use the appeals process.

Appeals and grievances.

Although CMS tightened and improved the process in the final regulations, the appeals and grievance process remains cumbersome and very difficult for people with cognitive impairments. Many physicians are not willing to participate in an unwieldy process. In addition, unlike current Medicaid requirements, the Medicare Part D plan is not required to supply the medication until the appeal process is completed. Many people in this population do not have the ability to purchase medication on their own, resulting in the lapse of coverage of critical medications for some.

Recommended Solution:

1. Regulation. Part D plans should be required to provide coverage throughout the appeal process. In addition to assuring access to needed medication, this will provide an incentive to the Part D plan for timely resolution.

Home and Community-Based Services

Oregon has an extensive community-based long-term care system for both seniors and people with disabilities, including assisted living facilities, residential care facilities, adult foster homes, and group homes. Many facilities and homes individually order all medications and actually administer medication to the clients. Current regulations exclude individuals living in community facilities from the definition of "institutionalized", although by definition in the basic CMS requirements to obtain a Home and Community-Based waiver, these individuals meet "institutionalized" level of care.

Individuals residing in these community facilities must contribute toward the cost of their services and have very limited resources. By excluding them from the definition of "institutionalized", they will be subject to additional copays for their medication. In addition to having extremely limited funds to cover even those minimal costs, they have no real control over their medications and therefore, the copay does not provide an incentive to become a smart consumer. Moreover, it places the facility in the untenable position of collecting the copay from the resident, in order to get medications.

In addition, it is not clear in the current regulations if individuals residing outside of institutions will have access to Long-Term Care pharmacies. These pharmacies provide needed special medication packaging, Medication Administration Records, and other safeguards necessary to ensure that long-term care facility staff – be they staff of a nursing facility, assisted living facility, foster home or group home, safely administer the medications.

Recommended Solution:

1. Regulation. CMS should include individuals residing in community-based facilities in the definition of institutionalized.

2. Regulation. CMS should also require the Part D plans to allow access to Long-Term Care pharmacies for individuals residing in community-based facilities.

Institutions

Nursing and other facilities face unique challenges. They rely upon Long-Term Care pharmacies for vital services to ensure the safe administration of medications. CMS acknowledged this importance in the final regulations. Oregon is concerned, however, that the definition for "dispensing fee" for those pharmacies does not include all of the necessary services from these pharmacies, such as Medication Administration Records, drug reviews, and emergency drug supplies.

Oregon is also concerned about the definition of "institution" in the final regulations. States are currently working with CMS to understand exactly which Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) and psychiatric hospitals are included in the expanded definition of institution in the final regulations. It is extremely important that those institutions that serve Medicare/Medicaid dual eligibles have both access to Long-Term Care pharmacies and the clients are exempted from copays.

Finally, as drafted, the regulations do not appear to create a process by which institutions will know the Part D plans that their clients have chosen. The enrollment process is centered on the individual beneficiary interacting with CMS and the Part D plan. However, facilities have the responsibility for ordering the medications and administering them. Without the ability for facilities to know the Part D plan that an individual has chosen, they will not know the pharmacy available to them.

Recommended Solution:

1. Regulation. The definition of dispensing fee needs to be revised to include the other necessary costs of safe delivery of medication in these settings or another mechanism developed to ensure that these services are provided and reimbursed by the Part D plans.
2. Regulation. The definition of institution needs to include all Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) and psychiatric hospitals that serve Medicare/Medicaid beneficiaries.

3. A process needs to be developed to inform the facility of the client's choice. This may require regulation to allow sharing of this information.

Coordination of Care

Even with the transfer of the drug benefit to Medicare, state Medicaid agencies will continue to provide health services to dual individuals. To assure optimal health care coordination for those individuals, states, without cost, must have access to information on individual-specific medications supplied to dual Medicare/Medicaid eligibles. Under the current rules, CMS will only require Part D plans to share that type of data if the state also has risk in the costs.

Recommended Solution:

1. States should be permitted to have access to information regarding medications supplied to all Medicare/Medicaid dual eligibles and should not be required to purchase it. It is not clear if this would require statutory authority or regulation.

Low-Income Subsidy Eligibility Determination

Medicare beneficiaries qualify for the low-income subsidy in two ways: (1) being eligible for Medicaid and other programs for which states currently have responsibility for eligibility determination or (2) by meeting new and different income and resource standards delineated in the Medicare Modernization Act. Oregon believes that it fulfills its statutory authority to perform subsidy eligibility determination through its existing eligibility determination responsibilities for Medicaid and other programs.

Although CMS and the Social Security Administration (SSA) are establishing a system that will attempt to direct most of the beneficiaries eligible under the new standards to SSA, the CMS final regulations require states to establish a parallel process if a beneficiary demands that the state process the application. This creates an untenable situation for states who have received no additional funding, beyond the offer to provide federal matching, to support this mandate.

In Oregon, SSA plans to send 264,000 letters to Medicare beneficiaries alerting them of their potential eligibility for the subsidy. It is unknown how many of those individuals actually are eligible. It is also unknown how many will demand that the state, as opposed to SSA, process their application. States must prioritize their already limited resources for the population. This additional workload, the primary burden of which will fall during a critical point in state planning for Part D enrollment, has the potential to totally overwhelm the state's ability to successfully transition those most vulnerable individuals who are dually eligible.

Recommended Solution:

1. Regulatory, potentially Statute. Regulations need to be clear that States only have responsibility for those Medicaid populations for whom they currently perform eligibility determinations.

EPSDT Coordination

Medicaid regulations require the State to provide all medically necessary services for children discovered in Early Periodic Screening, Diagnosis and Treatment (EPSDT) examinations. Although the numbers are small, there are children who are both Medicare and Medicaid eligible. Since the drug benefit for duals is no longer the Medicaid responsibility, states should not be required to comply with the EPSDT requirement without federal participation.

Recommended Solution:

1. Regulation. CMS should revise the EPSDT requirement to clarify that states are not responsible for providing medications for these children.

Excluded Part D Medications

Benzodiazepams and barbiturates are excluded from drug coverage under Part D. Although, this may have made sense decades ago when the misuse of Valium and phenobarbitol was common, it is unclear why this outdated exclusion is being continued in Medicare Part D. This exclusion would impact access to important medications for seizure control, for the anxiety common with dementia, and for some psychiatric medication side effects.

Although these classes of medications will not be considered Part D medications, CMS is allowing Part D plans to include these medications as an enhanced benefit. This creates communication and coordination of benefits issues for states. Oregon will continue to cover these classes of medication. How will we know when individual plans agree to cover the medication?

Recommended Solution:

1. Statutory or Regulation. Remove these classes of medications from the excluded list.

Conclusion

Thank you, members of the Senate Special Committee on Aging, for holding this hearing on these important matters. We understand that everyone is interested in the safe and healthy transition of this vulnerable population to this new benefit. We appreciate the extensive work completed by CMS toward this end and believe that the changes outlined above would provide additional protection for Medicare recipients to ensure their successful enrollment in the Medicare Part D benefit.