



Laurel Heights
Room 340, Box 0646
San Francisco, CA 94143-0646
Tel: (415) 502-5200
Fax: (415) 476-3915

Implementing Medicare Part D in California: A Scan of the Landscape

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**Norman Fineman, Ph.D.
Sheryl Goldberg, Ph.D.
Walter Gomez
Lacey Huang Orsini
Tiffany Martin, M.A.
Brooke Hollister
Carroll L. Estes, Ph.D.**

**Institute for Health & Aging
University of California, San Francisco
3333 California Street, Suite 340
San Francisco, CA 94118**

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Final Report to The California Endowment MMA Scan Project

Overview of Report

Beginning in 2006, 4.4 million elderly and disabled people on Medicare in California will have access to prescription drug coverage through Part D of the Medicare program. The Medicare Prescription Drug Improvement and Modernization Act (MMA) provides the largest benefit expansion in Medicare's history while enacting major changes to the program's structure. Understanding these changes is essential for understanding: (1) how the program will be implemented, how beneficiaries will be informed about the program, and how they will be enrolled; (2) what the gaps in current implementation efforts are, and what strategies may be appropriate to resolve them; and (3) why there is much confusion and misunderstanding among key players about the program.

This two-month study was conceived as a "scan of the landscape" to examine California's readiness to implement the MMA by describing the implementation activities of various public and private health, advocacy, and funding entities in the state, investigating respondents' sense of the challenges to implement the program and the strategies needed to meet these challenges, and examining and assessing gaps in implementation activities. To do so, we interviewed 54 key informants in 46 public and private, state and national entities including government departments, health and aging advocacy organizations, professional associations, and CBOs, and conducted web searches of all the organizations we contacted (See Appendix I). The report scans California's readiness to implement the MMA in light of the major structural changes that are about to occur, assesses the strengths and weaknesses of implementation efforts, identifies gaps in program activities, and suggests strategies for closing some of the identified gaps.

The report's methods are described in Appendix II.

Report Highlights:

- The MMA is a minimally regulated private insurance program, a business model that shifts much if not most of the responsibility for implementing the program from the federal government to private insurers.
- Implementation of the MMA will likely be severely challenged by: significant deficiencies in locating and outreaching to vulnerable and minority populations that are eligible for the Medicare low-income subsidy (LIS); a shortage of counselors to assist beneficiaries in understanding the Medicare Part D program; and the virtual absence of programs to directly assist Medicare Part D beneficiaries in choosing, and filling out the application for a prescription drug plan (PDP) or a Medicare Advantage Plan (MA-PD).
- The most urgent and pressing needs are to:
 - (1) Develop educational materials and outreach strategies for individuals who speak languages other than English, Spanish, and Chinese;
 - (2) Create a clear, specific and detailed strategy to ensure no gap in coverage for dual eligibles who will lose Medicaid drug coverage on January 1, 2006;

- (3) Identify and make effective contact with individuals who may qualify for the low-income subsidy, but who will not be automatically enrolled;
- (4) Hire and train counselors to assist members of vulnerable populations with issues of eligibility, enrollment, and appeals, including seeking exceptions when needed drugs are not on formulary or are on a high copayment tier;

I. BACKGROUND

Complex Structure of the Medicare Part D Program

The complex structure of Medicare Part D contains both public needs-driven and private market-driven components and implementation strategies. Combining these two disparate components makes for an uneasy alliance, which renders the program difficult to understand and difficult to implement. Understanding the nature and scope of the structural changes about to occur under Part D of the MMA is critical for understanding its key features, limitations, and gaps in implementation.

Privatization of the Part D Program

Unlike Medicare Parts A, B, and C, which are public programs, Medicare Part D is organized as a network of regional and national private insurance programs—offered largely by insurance companies and retail pharmacies, but other entities as well—that have been approved by Medicare. The private insurance programs may be organized either as stand-alone prescription drug plans (PDPs), or as part of a Medicare Advantage plan (MA-PD).

Departing significantly from prior Medicare practices, the federal government, through the Centers for Medicare and Medicaid Services (CMS), the administrative arm of Medicare, will select and contract annually with these entities to provide all Part D services. While the federal government will provide generic information about the MMA to the public through a massive media campaign, promotional tours, community events, mailings, brochures, and telephone- and internet-based support, it is the individual insurance providers, and not the federal government, that will be responsible for educating the public about the available PDPs and MA-PDs, and for enrolling potential beneficiaries in those plans. They, and not the federal government, will establish premium prices and will negotiate drug prices with pharmaceutical manufacturers (See Note 1). Under the MMA, CMS establishes minimal standards to guide the substance and implementation of the approved individual private plans (See Note 2).

In sum, Medicare Part D is a federal government-approved private insurance program. However, the program also provides important federal government monetary support for people with low incomes, whereby it takes on the characteristics of a traditional needs-driven public program.

The Low-Income Subsidy (LIS)

The low-income subsidy (LIS) gives low-income people earning less than 150% of the federal poverty level help paying the costs of coverage under Medicare Part D. There are income and

resource requirements similar to those used for SSI, with slightly higher cutoff figures (See Note 3 for a specification of LIS benefits).

Many low income persons, including all dual eligibles—those individuals eligible for or receiving benefits from both Medicare and MediCal—as well as others just above the poverty level, are eligible for a subsidy to lower the cost of Part D prescription drugs. The dual eligibles will be identified by MediCal and Medicare and be automatically enrolled in a Medicare Part D prescription drug plan and receive the low-income subsidy if they do not enroll in a plan of their own choosing by December 31, 2005. The plan they are automatically enrolled in will be randomly chosen, and there is no guarantee that it will be the plan with a drug formulary best suited to the beneficiary's individualized medical needs (See note 4).

When potential beneficiaries do not qualify for automatic enrollment in a PDP—those individuals not receiving MediCal, but with incomes below 150% of the federal poverty level—the Social Security Administration (SSA) will attempt to identify them by inspecting the records of other federal agencies including the IRS, and sending potential beneficiaries an application for the extra LIS assistance.

All other Medicare beneficiaries will need to enroll in a Medicare Part D plan and separately apply for the low-income subsidy, to receive the subsidy. Applications for the low-income subsidy will be taken at Social Security offices, or online on the Social Security website, and at state Medicaid offices starting on July 1, 2005.

Implications of Structural Changes for Implementing Part D Benefits

There are several important implications of designing the MMA primarily as a private insurance program with some limited public assistance for low-income beneficiaries:

- Recent announcements suggest that there will be a large and, potentially, confusing assortment of plans available in California, making choice of any one plan difficult, especially for vulnerable individuals with cognitive impairments, low health literacy or who do not speak and understand English;
- Contract rules governing the conduct of the PDP providers and beneficiaries raise difficulties for beneficiaries, such that:
 - i. providers are free to change formularies with 60-days' notice, but beneficiaries (except for LIS-eligible beneficiaries) must remain in a plan for at least one year;
 - ii. the process for appealing a PDP plan's benefits decisions is complex, long, and arduous.
- Information about the specific PDPs will be provided through corporate advertising by the PDPs rather than by a government-sponsored public education campaign;
- As a program consisting of competing providers in a market, the traditional role of government to provide an overarching state or federal organizational structure for coordinating the implementation efforts of all the stakeholders has been dramatically reduced;

- Premium prices of the PDPs will be set by insurers in negotiations with drug companies and retail pharmacies, rather than by the federal government. As a consequence, decision making about pricing will not be open to public scrutiny.
- While the MMA is a voluntary program, federal regulations have built into its structure a financial penalty to discourage potential healthy beneficiaries from delaying enrollment until they need the coverage, rather than enrolling in the program when they are first eligible to do so. The effect of this provision is unclear. (See Note 1).

Potential Impact of the MMA on Dual Eligible Beneficiaries

There are nearly one million low-income elderly and disabled “dual eligible” beneficiaries in California. California’s seniors and individuals with disabilities who are dually eligible for Medicare and Medi-Cal typically have higher medical expenses and lower income than the rest of the Medicare population. Compared to the rest of the Medicare population, this group is more often: sicker (more than 50% are limited in activities of daily living), cognitively impaired (almost 4 in 10 have a mental or cognitive impairment) dependent on multiple prescriptions; and institutionalized (almost ¼ are in long term care facilities.).

- Dual eligible beneficiaries will be randomly assigned to drug plans based upon cost, not individual drug needs. In order to avoid paying added premiums for Part D plans, low-income seniors and disabled beneficiaries must enroll in (or be assigned to) low cost plans, which could restrict their ability to access broader drug formularies.
- Continuity of care is not guaranteed. Since dual eligibles will be restricted to drugs covered by their Part D plan formularies instead of the current comprehensive Medi-Cal formulary, many may face gaps in treatment. Even short disruptions in drug regimens can have catastrophic consequences for individuals with chronic conditions, such as HIV/AIDS, mental illness and seizure disorders.
- Short transition period leaves no margin for error. Since Medicaid coverage ends the same day that Part D coverage begins, there is no margin of error concerning enrollment in Part D. This transition process requires perfect coordination between layers of state and federal databases, with no guarantees that individuals will not fall through the cracks and be left without any drug coverage at all.

While dual eligibles will not have to pay premiums for average cost drug plans, higher cost plans may better meet their individual drug needs, which could require them to pay added expenses for premiums. Even modest cost sharing requirements can lead to Medi-Cal beneficiaries forgoing treatment or even losing their health coverage. Medicare Part D also excludes certain drugs from coverage, most notably benzodiazepines, barbiturates and over-the-counter medications, which may be of concern for some dual eligibles.

(<http://pn.psychiatryonline.org/cgi/content/full/40/14/1>).

II. MMA IMPLEMENTATION ACTIVITIES OF ORGANIZATIONS SURVEYED

A central task of this study was to describe the MMA implementation activities of the organizations we surveyed. To do so, we scanned the websites of all the organizations we contacted, and in interviews with key respondents asked them to describe their organization's current and planned efforts to assist in implementing the MMA.

Respondents enumerated 38 different activities (see Appendix III for the complete list), which for analytical purposes, we coded into 11 categories. These included: professional training; outreach to minority and vulnerable populations; public education; counseling; enrollment assistance; mass media campaigns; partnering with other organizations; research; policy development; advocacy; and funding (See Appendix II for a description of the codes).

Description of Activities

Table I summarizes the broad range of implementation activities of the 40 organizations we surveyed on this question. We surveyed six kinds of organizations: federal agencies, national nongovernmental organizations, a national faith-based organization, California state agencies, California state and local nongovernmental agencies, and state professional organizations. The activities reported by respondents in descending order of frequency were: partnering with other organizations (73%), conducting public education (65%), conducting professional training (58%), advocating on behalf of seniors and Medicare beneficiaries assessing Medicare policy (50%), conducting outreach to the dual-eligible population and other LIS-eligible people (45%), providing individual face-to-face or telephone counseling to assist beneficiaries in enrolling in the LIS and understanding the MMA (33%), doing mass media advertising related to the MMA (25%), providing individual face-to-face or telephone counseling to assist beneficiaries in enrolling in individual PDPs (13%), conducting research (10%), and funding MMA-related program activities (8%).

Scan of Current Efforts

Partnering. With few exceptions, the organizations we contacted worked in collaboration with other organizations to assist in implementing the MMA. Virtually none of the California state organizations we contacted worked alone. Although many of the coalitions in California have overlapping memberships, there is no interorganizational structure in place. The lack of an overarching organizational structure has prompted concerns that various coalitions may be duplicating each other's efforts. We found little evidence that duplication of effort presents a problem in California. To the contrary, given that most of the duplication in effort relates to LIS outreach, education, and enrollment activities, and given that duplication of these activities will increase the likelihood of targeting and identifying hard-to-identify and locate vulnerable individuals and help insure that the maximum number of individuals eligible for the LIS will be covered by it, we assess duplication of effort as an insignificant problem.

The strength of the coalitions we surveyed was to build capacity for information sharing and dissemination among coalition members. But, ironically, the greatest limitation of the coalitions surveyed was the lack of specific information about the MMA made available to them to share

and disseminate. One of the greatest challenges to implementing the MMA cited by respondents was the lack of information they had from the federal government about the details of the individual PDPs and formularies.⁶

Some of the most wide ranging and successful collaborations we surveyed were:

- Administration on Aging (AoA) [See Appendix IV for detailed description of partners/network]
- Access to Benefits Coalition (ABC) [See Appendix V for detailed description of California membership and programs]
- Health Assistance Partnership (HAP) [See Appendix VI for detailed description of California membership and programs]
- Health Consumer Alliance (HCA) [See Appendix VII for detailed description of California membership and programs]
- Health Access California (HAC) [See Appendix VIII for detailed description of California membership and programs]
- California Health Advocates (CHA)/HICAPs/California Medicare Coalition (CMC) [See Appendices IX and X for detailed description of California membership and programs]

HICAP is a volunteer-supported program that provides unbiased information to help Medicare beneficiaries make the best choices for their individual health care needs. Local HICAP volunteers, who receive many hours of continuing training and are registered with the State of California, offer generic information and counseling—what one HICAP official called “neutral technical assistance”—on: Medicare and Medi-Cal coverage; Medicare benefits and rights, claims, appeals, and denials; changes in Medicare and Medicare-related coverage; legal help and representation at Medicare appeals and administrative hearings; private supplemental insurance (MediGap) coverage; Medicare Advantage plans (formerly known as Medicare HMOs) and Medicare+Choice plans; retiree or employer group health coverage; long-term care insurance; health care consumer rights; and referral to community-based social and aging program services.

Public Education. Public education through the creation and dissemination of educational literature, sponsorship of community presentations, and design and publication of web-based information and benefits and eligibility calculators represents the single most important mission of the organizations we surveyed. Almost two-thirds of the organizations we surveyed had programs in place to educate the public about eligibility for and enrollment in the LIS and about the Part D program in general.

Although a current Kaiser Family Foundation study (2005) (http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=27620) reports that only 1/3 of seniors (age 65+) has access to facility with using the internet, we include web-based education here as an important source of information for those older adults who may be computer literate or have younger computer-literate friends and family members who can help them make program and eligibility decisions about the MMA. Nevertheless, many vulnerable,

poor, low-literacy, and ethnic and racial minority LIS-eligible seniors may not have access to, be able to understand, or benefit significantly from web-based information sources so over-reliance on this source of education may not reach many seniors.

We identify five education programs that target and outreach to specific vulnerable groups, have superior dissemination capabilities, and focus on producing educational materials in languages other than the English, Spanish, and Chinese.

- Access to Benefits Coalition (ABC) [See Appendix IV for detailed description of California membership and programs]
- California Health Advocates/HICAPS/ California Medicare Coalition [See Appendices IX and X for detailed description of California membership and programs]
- Health Consumer Alliance (HCA) [See Appendix VII for a detailed description of California membership and programs]
- World Institute on Disability (WID) [See Appendix XI for a detailed description of WID's interests and programs]
- National Asian Pacific Center on Aging [See Appendix XII for a detailed description of NAPCA's interests, programs, and California members]

Professional Training. Training various service professionals such as health and elder counselors, organization leaders, health professionals, and advocates is a critical need for assisting implementation of the MMA. Nearly three-quarters of the organizations we surveyed reported that lack of time and/or funding to hire and train trainers was a significant challenge of implementing the MMA. Nevertheless, more than half of the organizations we surveyed had some, albeit limited capacity for training professionals. Some examples are:

- California Health Advocates (CHA)/ HICAPS [See Appendix IX for detailed description of California membership and programs]
- Health Assistance Partnership (HAP) [See Appendix VI for detailed description of California membership and programs]
- National Senior Citizens Law Center (NSCLC) [See Appendix XIII for NSCLC interests and programs]

Advocacy/Policy. More than half of the organizations we contacted advocate on behalf of elders, vulnerable populations, or Medicare beneficiaries. These organizations have played an important role in shaping the national conversation about the MMA and its implementation, and will no doubt play an important long-term role in addressing the legislation's acknowledged limitations and problems. The organizations below exemplify important advocacy efforts:

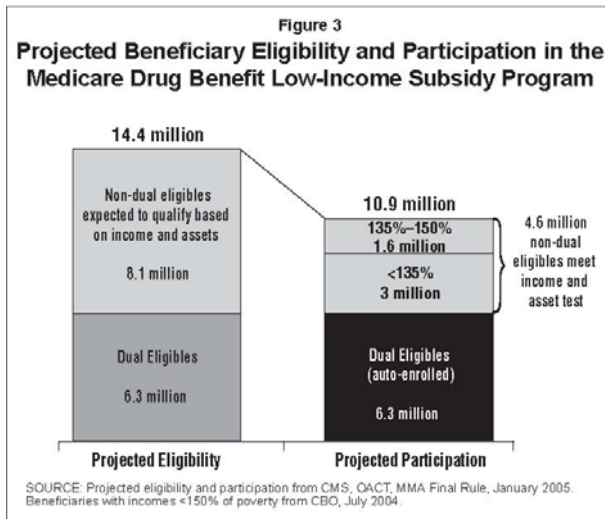
- California Health Advocates (CHA) [See Appendix IX for detailed description of California membership and programs]
- Health Access California (HAC) [See Appendix VIII for detailed description of California membership and programs]
- National Council on the Aging (NCOA) [See Appendix XIV for program details]

- National Senior Law Center (NSCLC) [See Appendix XIII for NSCLC interests and programs]
- World Institute on Disability (WID) [See Appendix XI for a detailed description of WID's interests and programs]

LIS Outreach. Outreaching to and enrolling dual eligibles and other LIS-eligible individuals into the LIS program represents the single most cited challenge to implementing the MMA. This population is especially at risk for health problems associated with greater use of pharmaceuticals. Beneficiaries with incomes below 150% of poverty are nearly twice as likely as higher-income beneficiaries to be in fair or poor health, have cognitive mental impairments, or live in a nursing home. The low-income subsidy-eligible population also includes a disproportionate share of women, racial/ethnic minorities, beneficiaries who are 85 or older, and those who are under age 65 with disabilities.

Outreach programs are crucial for finding and enrolling those vulnerable and poor individuals that are not dually eligible for benefits. Only dual eligibles, those who receive premium and/or cost-sharing assistance from Medicaid through the Medicare Savings Programs (QMB, SLMB, QI), and those eligible for SSI cash assistance are automatically deemed eligible to receive the LIS and need not apply separately. Other low-income beneficiaries, however, must apply through the Social Security Administration (SSA) or their state Medicaid program to receive the LIS. If they wait until the Spring of 2006, their enrollment will be facilitated by CMS. In California, the number of LIS eligible, but not dually eligible auto-enrolled beneficiaries, is roughly estimated to be between 420,000 and 500,000 individuals (from 2003 CHIS data; CMS from CBO, July 2004).

Historically, relatively small percentages of eligible seniors and people with disabilities have enrolled in many needs-based government benefit programs, even after many years of effort. For example, only 53% of the elderly who are eligible for SSI are enrolled in the program, and just 30% of the senior citizens who are qualified for Food Stamps currently are receiving them. CMS estimates that only 4.6 million of the 8.1 million non-dual eligible persons in the U.S. that qualify for the LIS will actually participate in the program (See Figure below). Thus, nationally, 3.5 million individuals who qualify for the LIS are projected to not participate. Part of the problem stems from the circumstance that many non-dual eligible LIS beneficiaries will enter the program through the SSA, which will not screen applicants for Medicare Savings Program eligibility or necessarily refer low-income subsidy applicants to their state Medicaid programs for additional benefits or assistance. Only state Medicaid programs must screen for eligibility for benefits under the Medicare Savings Programs.



Current strategies for identifying and targeting LIS-eligible individuals include mass mailing of information to dual eligibles (CMS, SSA), mass media campaigns (CMS, SSA, CHA), use of IRS data to locate low-income individuals (SSA), use of beneficiary rolls of other federal and state programs such as energy assistance programs and the National Association of Area Agencies on Aging client list to identify low-income individuals (NCOA), targeted outreach to ethnic and racial minorities using mailings and/or sponsoring local community events (HCA, NAPCA), use of church-based outreach, and use of door-to-door volunteers to provide information (United Methodist Association).

Outreach to vulnerable population groups will be especially important. In particular, ethnic and racial minorities particularly Latinos, Asian/Pacific Islanders, African Americans and Native Americans; refugees; non-English speakers; people with low health literacy, people with disabilities; the mentally ill; people in institutional settings; and the home-bound will require targeted outreach strategies. Yet, there is a significant lack of language and cultural competence with CMS and many traditional outreach organizations. For example, CMS, while sending out mailings in six languages other than English (Spanish, Chinese, Korean, Vietnamese, Tagalog, and Russian), and posting instructions for the LIS on their website in 14 languages, will accept applications for the LIS in English or Spanish only; SSA is mailing informational packets in English and Spanish only.

LIS outreach and enrollment by CMS, SSA, and the Access to Benefits Coalition (ABC) commenced earlier this year. Based on our interview data, response to these initiatives has been tepid. A communications official of Social Security told us that they mailed 1.6 million LIS applications in California and started processing them on 7/1/05. When asked about the response rate, she replied that neither CMS nor SSA have released data as yet on returned applications. An ABC representative told us the same thing. Similarly, a HICAP director told us that the federal outreach efforts “have not generated a lot of response,” possibly because the HICAP 800 phone number was not given in the information package.

We list these organizations because they demonstrate a concern and a capacity for language competence:

- Health Consumer Alliance (HCA) [See Appendix VII for a detailed description of California membership and programs]
- HICAPs [See Appendix IX for detailed description of California membership and programs]
- National Asian Pacific Center on Aging [See Appendix XII for a detailed description of NAPCA’s interests, programs, and California members]

Counseling. More than 40 percent of survey respondents cited one-to-one individual telephone-based or face-to-face counseling as the most effective strategy for educating seniors about the MMA, and especially for assisting seniors in understanding the complexity of the MMA’s plan structure and benefits and eligibility, penalty, and appeals rules and how to enroll in the LIS and individual PDPs. While many organizations had the capacity to provide some types of generic information to beneficiaries about the LIS benefit and the MMA program, very few organizations had the capacity to provide one-on-one, face-to-face or telephone-based counseling, to support beneficiaries in enrolling in the LIS or in individual PDPs. Among those respondents who cited counseling as an essential service, almost all pointed out that the use of individual beneficiary counseling (“hand-holding”) is the best and most critical strategy for assisting vulnerable, poor, and non-English-speaking seniors in enrolling in the LIS and filling out the necessary application forms.

- HAP [See Appendix VI for detailed description of California membership and programs]
- HCA [See Appendix VII for a detailed description of California membership and programs]
- HICAPs [See Appendix IX for detailed description of programs]
- National Asian Pacific Center on Aging [See Appendix XI I for a detailed description of NAPCA’s interests, programs, and California members]
- United Methodist Association [See Appendix XIV for detailed program information]

PDP Enrollment. Currently, enrollment activity focuses solely on enrolling beneficiaries in the LIS. PDP enrollment will not commence until November 15, 2005. When it does commence, however, it is still unclear, apart from insurance company advertising, whether and how information about the PDPs will be disseminated to the public. Only four of the organizations we contacted have explicit plans in place to assist beneficiaries in choosing a PDP. As of the beginning of September, HICAP officials reported wanting to provide this assistance, but were unclear about whether and how they will do so.

- ABC [See Appendix III for detailed description of California membership and programs].
- Health Consumer Alliance [See Appendix VI for a detailed description of California membership and programs]
- HICAPs[See Appendix VIII for detailed description of programs]
- National Asian Pacific Center on Aging [See Appendix XI for a detailed description of NAPCA’s interests, programs, and California members]

- United Methodist Association [See Appendix XIII for detailed program information]

III. GAPS IN AND LIMITATIONS OF CURRENT OUTREACH AND ENROLLMENT EFFORTS

Our survey suggests that there is inadequate funding to support the level of outreach, counseling, and enrollment programs necessary to reach the large number of beneficiaries in California.

Insufficient Funding

Calculating precisely the funding allocated to implement the MMA is difficult and beyond the scope of this scan. The funding sources of the MMA are numerous, various, and often not transparent. However, given the paramount importance of the issue for understanding the gaps in MMA implementation activities, we have tried to roughly gauge the level of funding available to support implementation of the MMA.

Section 1015 of the MMA states that up to one billion dollars is being allocated nationally to CMS, and that \$500 million is being allocated to SSA in start-up funding to pay for the administrative costs for the MMA in FY04-05.

(http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_bills&docid=f:h1enr.txt.pdf) A budget fact sheet issued by CMS dated 02/07/2005, states that Medicare's discretionary budget proposal for FY2006 includes continued funding for critical implementation activities in FY06, and that CMS is accounting for these funds separately from other funding sources and taking steps to ensure that it is used only to implement the MMA. About forty-three percent of these funds are being spent on education and outreach; only 4.8 percent is being spent on payroll. Additional funds are being directed toward information technology improvements and other systems activities. (<http://www.cms.hhs.gov/media/press/release.asp?Counter=1350>)

When we asked a federal official at CMS about funding to implement MMA, he stated that CMS is spending \$300,000,000 nationally over three years to fund MMA education, telephone counseling, and generic enrollment assistance, which will fund the MMA beneficiary handbook to be mailed to all SSA beneficiaries, their 800 telephone helpline, and their website. Thus, this funding is earmarked for centralized implementation efforts originating in Washington D.C.

However, it appears that little CMS funding has been apportioned to the state health insurance programs (SHIPs, which are the HICAPs in California) to help aid implementation on the local level. A CMS official stated that in 2004/2005, \$31 million was allocated to the SHIPs nationwide for MMA outreach, education, and enrollment. California's share of these funds in 2004/2005, he stated, was \$2.4 million, less than eight percent of the total available funding, and that a similar amount was being spent in FY 2005/2006. As Californians represents fully 1/6 of all dual eligibles in the nation and is home to 4.1 million Medicare beneficiaries, this \$2.4 million in total implementation funding translates to spending per beneficiary of less than 60 cents.

In addition to federal funding, the California state budget also apportions funding to implement the MMA. Although greater than the federal effort, this funding, too, is rather modest. In the most recent state budget, \$3.9 million (\$1.6 million General Fund) was allocated for outreach activities for Medicare Part D, and \$788,000 (\$569,000 General Fund) was allocated for outreach and support to patients in the state hospitals.

Thus we can estimate that total current state and federal funding to implement the MMA in California is approximately \$7.1 million, or about \$1.69 per eligible Californian. Extrapolating data from a recent Access to Benefits report, the amount of funding needed to implement the MMA in California is ten times that amount, or about \$72.0 million, in order to support the needed level -- hundreds of thousands of hours -- of one-on-one assistance to beneficiaries. <http://www.accesstobenefits.org/library/pdf/ABC%20ReportFNL62305.pdf>.

Insufficiency of Outreach Programs to Vulnerable and LIS-Eligible Populations

A majority (51%) of our key informants noted that current outreach efforts to locate and inform vulnerable populations about the MMA including the poor, disabled, institutionalized, ethnic and racial minorities, and non-English speaking individuals, are insufficient.

We asked a Social Security Administration official to describe SSA's outreach efforts in California. This official responded that 1.6 million LIS applications were mailed to potential LIS-eligible beneficiaries in July of this year, and that the plan is to enroll 90 percent of LIS-eligible beneficiaries by 12/31/2005.

The Administration of Aging is implementing some efforts to outreach to vulnerable populations, such as assisting CMS in locating relevant organizations to contact, and local CBOs with funding are targeting their individual communities. An AoA official noted that the National Association of Area Agencies on Aging in conjunction SHIPS (HICAPS in California) are currently conducting an "enrollment assistance capacity assessment".

Many respondents noted that in California, the HICAPS are the logical entity to organize and direct local outreach efforts because they have offices in every California county, know the local populations, have a trained staff of counselors that work individually with beneficiaries to resolve enrollment problems, and are charged with the responsibility of assisting all Medicare beneficiaries. However, they lack the funding and staffing to do so.

Lack of PDP Enrollment Programs and Lack of Counseling Programs to Facilitate PDP Enrollment for all Medicare Beneficiaries

Two important effects of designing the MMA as a privatized program in which the major responsibility for enrollment falls to private insurers are: (1) the lack of a concerted federal effort to direct and coordinate MMA outreach, counseling, and enrollment efforts; and (2) that given the lack of federal coordination, many organization leaders were uncertain or misinformed about who exactly is responsible for enrolling seniors in the program. For example, some believe that in California, the HICAPS were responsible for doing direct enrollment, while others believe that pharmacists and physicians are going to assist beneficiaries in enrolling.

Among our sample, fully 70% percent of respondents identified the lack of enrollment programs and the lack of counseling programs to assist enrollment as critical deficiencies of the MMA implementation plans. About one-third of the organizations we surveyed offered any kind of individual face-to-face or telephone hotline counseling services to assist enrollment, and only five (13%) of organizations had explicit plans in place to assist beneficiaries directly with PDP enrollment.

One federal official observed that there is “no real federal enrollment assistance” for the MMA because that function has been given over to the private insurers offering the individual PDPs. The federal role in implementing the MMA focuses on selling the program to the public through a national media campaign using TV spots and other advertising, and providing generic information about the program to community, advocacy, and service groups.

In California, as in other states, the job of enrolling beneficiaries might have fallen to any or all of three groups of MMA first responders: the HICAPS, which already provide Medicare counseling to beneficiaries; pharmacists who have medication expertise and a vested interest in successfully implementing the MMA; and physicians, who know their patients and their patients’ medication needs. However, each of these groups is prohibited by federal statute or policy from performing the role of PDP enrollment.

HICAP counselors are prohibited from giving advice to beneficiaries about choosing a particular prescription drug plan (PDP) because their mandate specifically prohibits them from “selling, recommending, or endorsing any insurance product, agent, insurance company, or health maintenance organization (HMO)”, activities that are seen to represent potential conflicts of interest. Nor are they permitted to help beneficiaries apply for or fill out the required forms for individual PDPs. Recently, however, some HICAP officials have offered that HICAP counselors may, indeed, be able to assist low-income beneficiaries in enrolling in individual PDPs by helping them navigate a web-based enrollment decision tool that will be available shortly (See Appendix XIV).

The situation is identical for the same reasons for pharmacists and physicians. Neither group of providers is allowed under current regulations to recommend specific PDPs to beneficiaries. It is construed as a breach of professional ethics and as opening the door for conflict of interest charges.

Nor, for that matter, can the Social Security Administration or state or county health departments offer enrollment assistance with individual PDPs to beneficiaries. A California Department of Aging official said that he was uncertain whether or not his agency will disseminate enrollment information. And a leader of a California-based organization that advocates on behalf of people with disabilities, stated that he was “very worried” about the plight of people with mental illness. Under the MMA plan, he said, beneficiaries will “now have to enroll without any assistance from the county mental health departments. In contrast, marketing and insurance companies such as National Insurance Markets, Inc and others are already marketing PDPs.

Some rules governing PDP enrollment in the MMA are especially confusing. A spokesperson for the health coalition, an organization that provides MMA telephone hotline assistance, told us: “With the Helpline like ours, [we can] help with changing [beneficiaries’] plans but not finding the plan in the first place. Once they [beneficiaries] find a plan, then they can call our helpline for information to switch.”

As a consequence of all these enrollment restrictions, no respondents believed that the MMA program will meet CMS’s enrollment targets. Many pointed out that the situation could be analogous to that of implementing the transitional drug discount card previously offered through the MMA, for which only 10 percent of Medicare beneficiaries applied.

Who, then, can help beneficiaries, especially poor and vulnerable beneficiaries, enroll? A HICAP official suggested that “providers, family members, and social workers should actually [do the] enroll [ment].” What needs to happen, another HICAP official told us, is “there needs to be someone responsible for direct enrollment in each county. An entity needs to be designated to take care of the enrollment and it needs to be well-funded.”

IV. IDENTIFYING LIS-ELIGIBLE INDIVIDUALS

Based on California Health Interview Survey (CHIS) data, which break down the California LIS-eligible population by county and region, Wallace (2003) suggests that approximately 439,000 Californians meet LIS eligibility requirements because their income is below 150 percent of the federal poverty level (FPL), a figure that squares with data reported by other sources (Kaiser Family Foundation; CHCF). Table 2, below, displays the distribution of the LIS-eligible population in California by county/region (See also Figure 1 below).

Table 2. Distribution of the LIS-Eligible Population in California		
County/Region	Approximate Size of the LIS-Eligible Population	Percent of Total California LIS-Eligible Population
Los Angeles ¹	124,500	28%
San Francisco Bay Area ²	63,500	14%
Central Valley ³	41,000	9%
Orange County	35,500	8%
Sacramento Region ⁴	31,000	7%
San Diego	30,500	7%
Riverside	26,500	6%
San Bernardino	22,500	5%
Northern Region ⁵	18,500	4%
North Bay/Coast ⁶	18,000	4%
Central Coast ⁷	15,500	3.5%
Ventura	9,000	2%
Imperial	2,500	.5%
TOTALS	438,500	98%⁸

GEO 1: The large 14-county region of geographic area 1, comprising about 18,500 LIS-eligible persons, is serviced only by the HICAPS and two Area Agencies on Aging in

GEO 2: The 6-county region of geographic area 2, comprising about 20,000 LIS-eligible persons is serviced also only by the HICAPS and two Area Agencies on Aging.

GEO 3: The 8-county region of geographic area 3 including Sacramento comprises about 32,500 LIS-eligible persons. It is serviced by HICAPS in each county, Area Agencies in three counties; the Health Consumer Alliance in four counties, and offices of the Health Assistance Partnership and National Asian Pacific Center on Aging in Sacramento. Sacramento, comprising about 50 percent of the region's LIS-eligible population, has offices of all the agencies serving the region.

GEO 4: The 5-county Bay Area region of geographic area 4, comprising about 61,500 LIS-eligible persons is serviced by HICAP offices in each county, plus three offices of the Health Consumer Alliance, three AAA offices, two offices of NAPCA and ABC, and one office of Health Access California, the NSCLC, and the WID. All of the agencies have offices in Alameda County.

GEO 5: The 5-county region of geographic area 5, comprising about 15,500 LIS-eligible persons is serviced by HICAPS in each county plus three Area Agency on Aging offices.

GEO 6: The huge 12-county Central Valley of geographic area 6, comprising about 41,000 LIS-eligible persons is serviced by HICAP offices in every county plus Area Agencies on Aging in Stanislaus, Fresno, and Kern counties, and Health Consumer Alliance offices in Kern and Fresno counties.

GEO 7: The 4-county desert region of geographic area 7, comprising about 49,000, LIS-eligible persons, virtually all of them in San Bernardino and Riverside counties, is served by HICAP offices and AAA and ABC offices in both San Bernardino and Riverside counties.

GEO 8: The two-county Los Angeles region of geographic area 8, comprising the largest LIS-eligible population in the state, 133,000 persons, is serviced by all of multi-office agencies we surveyed including HICAP, HAC, HAP, HCA, NAPCA, and two Area Agencies on Aging.

GEO 9: Geographic area 9 contains only Orange county, which contains 35,500 LIS-eligible persons. Orange county is serviced by HICAP, AAA, ABC, HCA, and NAPCA

GEO 10: Geographic area 10 is made up of San Diego and Imperial counties. The area contains about 33,000 LIS-eligible people, and is serviced by HICAPs, ABC, two Area Agency on Aging offices, and two HCA offices.

Observations about the Distribution of LIS-Eligible Population

- Fully 28% of the LIS-eligible populations reside in Los Angeles, and of these 75% live in four L.A. areas: Metro, San Fernando, San Gabriel Valley, and South Bay
- Fourteen percent of the LIS-eligible populations reside in the San Francisco Bay Area
- Seven percent of the LIS-eligible populations reside in San Diego county

- Thus, about 50% of the California LIS-eligible population live in relatively compact Urban/Suburban areas of the state, which could simplify targeting and outreaching to them.
- The remaining 50% of the LIS-eligible population are spread out across the balance of the state, possibly making identifying and outreaching to them difficult.

Distribution of Statewide MMA Assistance Programs

Table 3 shows a county-level comparison of the geographic distribution of LIS-eligible individuals and available MMA assistance programs. When plotted on a map of the state, we can make some general remarks about the location and distribution of current available assistance programs. Our aim is to roughly gauge the availability and accessibility of service providers in each area of California in relation to the size of the LIS-eligible population in those areas in order to provide a framework for assessing the most underserved and vulnerable regions in the state.

Analysis of these data suggests that, with two exceptions, service agencies do exist in each area of California. However, whether they have the capacity and funding sufficient to meet the needs of the populations is not addressed by this analysis. Importantly, fifty percent of the LIS-eligible persons in the state live within a few regions of the state that have good representation of agencies: Los Angeles, the Bay Area, and Orange County.

However, two geographic areas in particular, areas 1 and 6, may be especially underserved. While there are only 18,500 LIS-eligible persons dispersed in Northern California in area 1, they are spread out over a very wide geographic area, and more than 25 percent of them (with the exception of those in Shasta county), do not currently have prescription drug coverage of any kind. And although there are HICAP offices in every county, the counties, themselves, are very large, making it difficult to identify and target the LIS-eligible population.

The other state region with potential outreach problems is area 6, the enormous and demographically diverse Central Valley. A large LIS-eligible population, about 41,000 people, reside here. In two counties, Madera and Tulare, the rate of elders without prescription drug coverage is greater than 25 percent. Within this region there are only two Health Consumer Alliance offices to offer MMA information in languages other than English, Spanish, and Chinese.

In sum, this analysis suggests that two regions of the state, the counties of the Central Valley, by virtue of their large and diverse LIS-eligible population, and the Northern Counties, by virtue of their large size, should potentially be targeted for building greater service capacity.

CONCLUSIONS

This study was conceived as a “scan of the landscape” to examine California’s readiness to implement the MMA by describing the implementation activities of various public and private health and advocacy entities in the state; investigating respondents’ sense of the challenges to implement the program, and the strategies needed to meet these challenges; and examining and

assessing gaps in implementation activities. We find that implementation of the MMA likely will be challenged by:

- Significant deficiencies in locating and outreaching to vulnerable and minority populations that are eligible for the Medicare low-income subsidy (LIS); and
- A shortage of counselors to assist beneficiaries in understanding the Medicare Part D program, and the virtual absence of programs to directly assist Medicare Part D beneficiaries in choosing, and filling out the application for, a prescription drug plan (PDP) or a Medicare Advantage Plan (MA-PD).

Additionally, we suggest that the most urgent and pressing needs are to:

- Develop educational materials and outreach strategies for individuals who speak languages other than English, Spanish, and Chinese;
- Create a clear, specific and detailed strategy to ensure no gap in coverage for dual eligibles who will lose Medicaid drug coverage on January 1, 2006;
- Identify and make effective contact with individuals who may qualify for the low-income subsidy, but who will not be automatically enrolled;
- Hire and train counselors to assist members of vulnerable populations with issues of eligibility, enrollment, and appeals, including seeking exceptions when needed drugs are not on formulary or are on a high copayment tier.

Two significant policy issues should also be explored to minimize disruption of access to critical pharmaceuticals:

- Create a state-funded wrap-around benefit to pay for nonformulary drugs and drugs excluded from Part D entirely, and further subsidies for partial-subsidy-eligible individuals; and
- Extend the transition period from MediCal to Medicare for dual eligibles in order to ensure that none of them lose prescription drug coverage.

The study highlights the implementation challenges in outreaching, educating and enrolling eligible beneficiaries in the LIS and then in an appropriate PDP. We also suggest that two areas of California in particular, the northern counties and the central valley, may pose outreach and enrollment difficulties by virtue of their large size, diverse populations, and limited number of service organizations.

Respondents made clear that there are significant concerns about the implementation of the MMA resulting from limitations in funding for and national coordination of outreach and enrollment activities for vulnerable populations, as well as the complexity of and confusion about the MMA program. This uncertain beginning is particularly of concern to the poor, disabled, institutionalized, low-literacy, and non-English speaking populations of California. Greater and urgent attention to and concern for these vulnerable populations is needed by policymakers in California and in Washington D.C. to ensure the needs of these populations will be well served.

Notes

1. Indeed, Medicare is forbidden by statute to negotiate prescription drug prices with pharmaceutical companies or retail pharmacies. The sole exception to the federal government's noninterference in the market pricing of Part D premiums is imposition of a mandatory penalty for late enrollment. Under statute, the CMS provides for assessing a cumulative 1 percent per month premium increase for all beneficiaries that do not enroll when they are first eligible. (The baseline established for assessing a beneficiary's penalty is the premium amount in effect on the date that he or she was first eligible to enroll. Thus, a beneficiary that enrolls two years after he or she is first eligible to enroll will incur a premium cost equal to the amount of the premium two years earlier plus a penalty of 24 percent.) The rationale for creating the penalty was specifically to increase the number of healthy beneficiaries in the insurance pool by discouraging healthy eligible beneficiaries without drug expenses from delaying enrollment. In fact, it may be an empty threat. A government official observed that the penalty may be meaningless because premiums, especially in California, will be very competitive in the initial launching of the program in order to grab market share. Thereafter, premium charges will likely increase each year, which would render the penalty meaningless since everyone, not just late joiners, would be paying higher premiums in subsequent years.
2. These are the CMS guidelines for establishing and regulating the MMA program:
 - Requiring that there be at least two independent plans operating within each of 38 defined geographic regions in the U.S.;
 - Requiring that plans offer at least two drugs within each the 146 listed classes of drugs established by U.S. Pharmacopoeia;
 - Ensuring that beneficiaries have "convenient access" to retail pharmacies;
 - Mandating that plans have a process for providing beneficiaries with nonformulary drugs, when they are medically necessary;
 - Requiring that plans provide "useful" information to beneficiaries, such as how formularies and medication management programs work, information on saving money with generic drugs, and grievance and appeal processes.
 - Requiring that plans inform beneficiaries at least 60 days in advance of removing drugs from their formulary, or changing their costs;
 - Providing that individual insurers may not cancel beneficiaries' coverage except for failure to pay the premium.
 - Providing nominal advertising and marketing guidelines to help plans structure their advertising campaigns;
 - Establishing a national open-enrollment period each year between November 15 and December 31, for coverage to begin on January 1;
 - Mandating a cumulative late enrollment penalty one percent per month for eligible beneficiaries who do not enroll when they are first eligible.

Figure 1: Cost-Sharing and Enrollment for Medicare Drug Benefit Eligibles in 2006

ELIGIBILITY LEVEL *	Premium	Deductible	Copay	Copay After Catastrophic Limit [§]	Coverage Gap	Enrollment
Dual-eligible (Medi-Cal) individual regardless of assets [†]	None	None	\$1/\$3 [‡] (generic/brand)	None	None	Auto-enrolled
Income below \$12,920 (\$17,321 for couples) meeting asset test	None	None	\$2/\$5 (generic/brand)	None	None	Facilitated by CMS
Income between \$12,920 (\$17,321) and \$14,355 (\$19,245) meeting asset test	25 to 75% of full premium, depending on income	\$50	15% of drug cost	\$2/\$5 (generic/brand)	None	Facilitated by CMS
Income above \$14,355 (\$19,245)	\$37 per month average	\$250	25% of drug cost	5% of drug cost	\$2,250 to \$5,100	Up to individual

* Income limits are tied to federal poverty guidelines, which are updated annually. Values shown reflect guidelines published in February 2005.

† Institutionalized dual-eligibles will have no cost-sharing responsibilities. However, beneficiaries receiving home and community-based waiver services or residing in assisted living facilities will be responsible for copayments.

‡ Dual-eligible beneficiaries with incomes above \$9,570 (\$12,830 couple) will have co-pays of \$2 (generic) and \$5 (brand).

§ Set at \$5,100 in total drug spending for 2006.

4. In addition to those individuals with full scope Medicaid benefits (full dual eligibles) persons who are on a Medicare Savings Program or MSP (these include: Qualified Medicare Beneficiaries, or QMB; Specified Low Income Beneficiaries, or SLMB; and Qualified Individuals, or QI) will also be deemed eligible for the low-income subsidy and will automatically be enrolled.
5. In some cases, it may be advantageous to apply at MediCal offices rather than at SSA to undergo screening for additional important programs like the MSP programs mentioned above, and/or to obtain other rights.
6. The probable reason that detailed information about the PDP plans is not currently available is that this information, rather than being public information, is proprietary. The timeframe for the release of this information is dictated by considerations of advertising impact strategies and budgets. Thus information about the individual PDPs will become available on 10/01/2005—six weeks before enrollment begins, a timeframe that will maximize advertising impact and cost efficiencies even if it does not fulfill the information needs of the provider organizations or the Medicare population.

Appendix I

Organizations Participating in Scan

- (1) Access to Benefits Coalition
- (2) Administration on Aging (AoA)
- (3) American Society on Aging
- (4) Association of California County Welfare Directors
- (5) California Alliance for Retired Americans
- (6) California Association of Homes and Services for the Aging
- (7) California Coalition for Mental Health
- (8) California Department of Mental Health
- (9) California Department on Aging
- (10) California Foundation of Independent Living Centers
- (11) California Health Advocates (CHA)
- (12) California Health Care Foundation
- (13) California Long-Term Care Ombudsman Association
- (14) California Medical Association Foundation
- (15) California Medicare Coalition (CMC)
- (16) California Pharmacists Association
- (17) California Primary Care Association
- (18) Center for Medicare Advocacy
- (19) Center for Medicare and Medicaid Services (CMS)
- (20) Consumer's Union
- (21) Consumer Health Advocates
- (22) Health Access California
- (23) Health Assistance Partnership
- (24) Health Consumer Alliance
- (25) Health Consumer Alliance (SAC)
- (26) HICAP, SF: Senior Action Network
- (27) HICAP, Alameda: Legal Assistance for Seniors
- (28) HICAP, Los Angeles: Center for Healthcare Rights
- (29) Latino Health Access
- (30) Medicare Rights Center
- (31) National Asian Pacific Center on Aging (NAPCA)
- (32) National Association of Area Agencies on Aging (N4A)
- (33) National Association of State Unites on Aging (NASUA)
- (34) National Council on Aging
- (35) National Senior Citizens Law Center

- (36) Protection and Advocacy Inc.
- (37) Social Security Administration (SSA)
- (38) Southeast Asia Resource Action Center
- (39) United Methodist Association/CAReX
- (40) World Institute on Disability
- (41-46)Others

Appendix II

Methods

This two-month study was conceived as a “scan of the landscape” to examine California’s readiness to implement the MMA by describing the implementation activities of various public and private health, advocacy, and funding entities in the state, investigating respondents’ sense of the challenges to implement the program and the strategies needed to meet these challenges, and examining and assessing gaps in implementation activities. To do so, we interviewed key informants in 47 public and private, state and national entities including government departments, health and aging advocacy organizations, professional associations, and CBOs, and conducted web searches of all the organizations we contacted.

Sample

The sample of interviewees derived originally from a list of organizations provided to us by TCE. We used this list as a starting point for recruiting potential key informants in those organizations, and then employed snowball sampling and web-based searches to identify and recruit additional potential informants. Introductory emails were sent to all potential participants, which were followed up with telephone calls to schedule interviews. In all cases, our interviewees were knowledgeable, highly placed personnel—directors, key administrators, or public relations executives—within their organizations. Although the sample was neither random nor comprehensive, it was, nonetheless, composed of individuals representing a broad range of organizations in and viewpoints relating to the state’s and nation’s efforts to implement the MMA. It thus captures the experiences and opinions of many key players in the ongoing debate about the MMA. A list of all the organizations surveyed appears in Appendix I. In all, we contacted 74 organizations of which 28 (37%) refused or were unable to participate.

Data Collection

Interviews. Interviews were conducted with 54 key informants in the 46 organizations we surveyed, and lasted between 30-45 minutes. Our aim during interviews was to engage interviewees personally in an effort to elicit candid and sincere responses. We asked them to speak from a personal as well as professional perspective. The interviews followed a standard format (See Appendix III), but we made an effort to probe respondents’ answers to questions, and follow up on their statements.

Interviews were conducted by a two- or three-person team using a speakerphone, whereby one team member asked questions and took notes and the other team member(s) only took notes. At the conclusion of the interview, all the notes were assembled, reviewed, and then combined into a single word-processed document. We found that this note-taking strategy produced comprehensive and accurate notes.

Web-Based Searches. Once an interview was scheduled, one member of the research team conducted a web search to find information about the organization and individual we were going to interview. These searches provided useful knowledge about the organizations we

contacted by helping to inform our questioning, elaborating on the interview data, or clarifying questions about them.

Data Analysis

Coding. Data coding began shortly after data collection began. The rationale underlying the creation of codes was what might be called "modified induction;" that is, although some coding categories were developed prior to interviewing, most of the coding was inductive and empirically grounded. We created codes by isolating themes in the data.

We envisioned data coding as an iterative process that would drive ongoing data collection, to create a form of continuing analysis to follow-up on emerging themes in the data.

Respondents enumerated 38 different activities (see appendix 2 for the complete list), which for analytical purposes, we coded into 11 categories of implementation activities. These included: professional training; outreach to minority and vulnerable populations; public education; counseling; enrollment assistance; mass media campaigns; partnering with other organizations; research; policy development; advocacy; and funding.

Description of Codes

1. Professional training refers to the recruitment and training of various professionals such as benefits counselors, organization leaders, and service providers through seminar and web-based training and conferences.
2. Outreach refers to activities related to identifying and locating key vulnerable target populations including ethnic/racial minorities, disabled people, non-English speakers, and the poor.
3. Public education refers to large- and small-scale activities that serve to inform the public about the MMA through: meetings at senior centers and community events; bulletins and newsletters; the creation and dissemination of educational materials; and web-based education including online eligibility and benefits calculators.
4. Counseling refers to individualized advice and information giving to beneficiaries to assist them in understanding the MMA program; their eligibility for low income support (LIS); and the LIS appeals process through face-to-face counseling and telephone hotlines.
5. Enrollment assistance refers to individualized face-to-face or telephone assistance to beneficiaries specifically to help them choose a particular prescription drug plan (PDP), Medicare Advantage plan (MA-PD, or regional preferred provider organization (PPO), and to help them fill out the appropriate application forms.
6. Mass media refers to television, radio, newspaper, and magazine advertising and information, and web-based information programs.
7. Partnering refers to collaborative activities with other organizations
8. Research
9. Policy
10. Advocacy
11. Funding

Appendix III

1. administering eligibility
2. advertising/media campaigns
3. advocacy
4. attending meetings, workshops
5. bulletins, magazines, newsletters
6. community events
7. comparing PDPs
8. coordinating training
9. counseling
10. creating education materials
11. disseminating educational materials
12. filling out applications
13. funding getting information from CMS
14. grant writing
15. helpline/hotline
16. hiring staff/counselors
17. identifying vulnerable groups
18. individual assistance
19. issuing alerts
20. making phone calls
21. outreach
22. participating in work groups
23. planning transition
24. policy work
25. representing beneficiaries at appeals hearings
26. presentations/seminars/meetings/conferences
27. recruiting volunteers
28. referring beneficiaries to other organizations
29. requesting money
30. research
31. screening for eligibility
32. sending letters
33. simplifying information
34. training other organizations' providers/groups
35. training staff/volunteers/counselors
36. translating educational materials
37. website
38. working with other agencies

Appendix IV

Administration on Aging/Area Agencies on Aging

Administration on Aging (AoA)

The Administration on Aging (AoA), an agency in the U.S. Department of Health and Human Services, is one of the nation's largest providers of home- and community-based care for older persons and their caregivers. Created in 1965 with the passage of the Older Americans Act (OAA), AoA is part of a federal, state, tribal and local partnership called the National Network on Aging. In California, this network, serving about 700,000 older persons and their caregivers, consists of the California Department on Aging and 21 Area Agencies on Aging. The state network of area agencies on aging and provide to older adults home-care, congregate and home delivered meals, transportation, information and assistance and advocacy on behalf of individual older citizens.

In regard to assisting and funding the implementation of the MMA in California, the AoA and the National Association of Area Agencies on Aging (N4A), through a supplemental grant from the U.S. Administration on Aging (AoA) under the Eldercare Locator Program, have launched an initiative to assist state and local aging agencies in their work to implement the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA).

To assist aging agencies in their efforts to outreach, educate, and enroll Medicare beneficiaries in Medicare's new prescription drug program, the AoA and AAAs are working with the Center for Medicare and Medicaid Services (CMS) to identify outreach targets and to fund the Health Insurance Counseling and Advocacy Programs (HICAPs) and community-based organizations (CBOs) for outreach, education, and enrollment. In addition, they direct and manage the Medicare Partner Campaign, which provides member organizations of the Aging Services Network with:

- updates and information through webinars and teleconferences;
- develop and disseminate promotional and technical assistance materials;
- provide on-going technical assistance and best practice profiles;
- provide a media tool kit that contains
 - a. Helpful hints on organizing an event,
 - b. A one-page description of the outreach campaign,
 - c. Sample media advisory for events,
 - d. Fact sheet designed for media contacts,
 - e. Sample press release to follow the event,
 - f. Sample editorial piece for local newspapers,
 - g. Fact sheets on Medicare Rx drug benefit basics for consumers, and
 - h. Six tip sheets on outreach to hard-to-reach populations.

The National Association of Area Agencies on Aging (N4A)

The National Association of Area Agencies on Aging (N4A) is the umbrella organization for the Nation's 655 Area Agencies on Aging (AAAs). There are 21 Area Agencies on Aging offices in California serving most California counties including those in rural and remote areas of California. They include:

- [Area 4 Agency on Aging - Sacramento](#) (Off Site)
- [Area Agency on Aging - Napa-Solano](#) (Off Site)
- [California State University - Chico Area Agency on Aging](#) (Off Site)
- [El Dorado County Department of Community Services](#) (Off Site)
- [Department of Aging and Adult Services - San Bernardino](#) (Off Site)
- [Fresno-Madera Area Agency on Aging - Fresno](#) (Off Site)
- [Kern County Area Agency on Aging - Bakersfield](#) (Off Site)
- [City of Los Angeles Department on Aging - Los Angeles](#) (Off Site)
- [City and County of San Francisco Commission on the Aging](#) (Off Site)
- [Los Angeles County Area Agency on Aging](#) (Off Site)
- [Monterey County Area Agency on Aging](#) (Off Site)
- [Orange County Area Agency on Aging - Santa Ana](#) (Off Site)
- [Riverside County Office on Aging - Riverside](#) (Off Site)
- [San Diego County Area Agency on Aging - San Diego](#) (Off Site)
- [San Joaquin County Department of Aging](#) (Off Site)
- [San Mateo County Aging and Adult Services Division](#) (Off Site)
- [Sonoma County Area Agency on Aging](#) (Off Site)
- [Stanislaus County Department of Aging & Veterans Services](#) (Off Site)
- [Council on Aging of Santa Clara County - Alameda](#) (Off Site)
- [Central Coast Commission on Aging - Santa Maria](#) (San Luis Obispo and Santa Barbara Counties) (Off Site)
- [Ventura County Area Agency on Aging - Ventura](#) (Off Site)

Appendix V

Access to Benefits Coalition

Chaired by The National Council on the Aging, the Coalition now has [104 national voluntary organization members](#). These include aging and health care organizations such as AARP and the Catholic Health Association of the U.S., national charities such as Easter Seals and groups representing those with health problems such as the Alzheimer's Association and the National Alliance for the Mentally Ill. In addition, faith-based and multi-cultural groups such as The National Council of Churches and the National Alliance for Hispanic Health are active members.

The goal of the Coalition is to quickly and measurably educate Medicare beneficiaries with lower incomes; help them make informed choices about prescription savings programs; and facilitate their actual enrollment in prescription savings programs by:

- Developing and using the best-available knowledge from the public and private sectors about best practices and cost-effective strategies for reaching and enrolling Medicare beneficiaries with lower incomes.
- Activating and supporting nationwide community education and outreach, focused on reducing confusion and providing beneficiary support in decision-making and enrollment.
- Developing and implementing a public information and outreach campaign.
- Developing a robust decision-support tool to help consumers make optimal choices.
- Mobilizing widespread support and participation in national, state and local Access to Benefits Coalitions.

ABC currently focuses on supporting financially and programmatically education about and enrollment in the LIS, and is dedicated to ensuring that Medicare beneficiaries with limited incomes and resources know about it. Because the history of efforts to enroll people with lower incomes in government benefits programs has been uneven, the coalition believes that massive public education as well as localized outreach and enrollment to those with limited incomes and resources are necessary outreach strategies.

Based on its own research, the California members are using four strategies to outreach to and enroll low-income beneficiaries in the LIS:

- On-site enrollment at community events
- Public speaking engagement with referral to telephone assistance
- Mass media with referral to telephone assistance
- Use of list strategies to outreach to low-income populations such as use of existing N4A client lists and lists of enrollees in low-income energy assistance programs

To reach beneficiaries with lower incomes, ABC is also partnering with both nonprofit, government and private organizations to produce educational materials, fund and train local and state coalitions as well as reach out to the media and both federal and state policymakers.

In addition, the ABC, together with the National Council on the Aging, has developed a useful web-based decision support tool, [BenefitsCheckUpRx™](#), to help low-income beneficiaries make informed decisions about their eligibility for the LIS and about the MMA in general. Limitations of this website are that: most low-income people do not have access to or use the internet; it is in English only; and it requires the user to have a good deal of precise and complicated financial information at hand.

Their funding efforts in California include a grant to the Alameda HICAP office to do targeted outreach regarding the Medicare discount card and Part D in Oakland and sponsoring a tri-county conference on Part D (SF, Alameda, San Mateo) targeted to provide education/training to disability providers. A grant to target Medicare Part D outreach efforts to low-income (150% poverty level) beneficiaries in Oakland and San Francisco (\$8,000 and \$25,000 respectively) through media outreach and special events is pending.

To meet its goals, the national coalition is involving and supporting hundreds of state and local organizations in communities nationwide. There are presently [56 local coalitions](#) around the country educating and enrolling beneficiaries in prescription savings programs. The five California members, three of which are N4A members or HICAPs, are listed below.

1. City of Los Angeles-Department of Aging;

James Don
Deputy Director
3580 Wilshire Boulevard, Suite 300
Los Angeles, CA 90010
Phone: (800) 510-2020
Fax: (213) 252-4020
Email: ageinfo@mailbox.lacity.org Los Angeles County CA

Serving: Los Angeles, CA

2. Council on Aging - Orange County

Cheryl Meronk
HICAP Program Manager
1971 E. 4th Street, Suite 200
Santa Ana, CA 92705
Phone: (714) 560-0424
Fax: (714) 560-0319
Email: cmeronk@coaoc.org Orange County CA

Serving: Orange County, CA

3. San Bernardino County Department of Aging and Adult Services Ginny Stafford

Staff Analyst
686 East Mill Street
San Bernardino, CA 92415-0640
Phone: (909) 891-3908 or (909) 891-3900

Fax: (909) 891-3919
Email: gstafford@hss.sbcounty.gov Riverside County CA
San Bernardino County CA

Serving: Riverside/San Bernardino Counties, CA

4. Aging & Independence Services, County of San Diego Tony Potter
Program Director
9335 Hazard Way
San Diego, CA 92123
Phone: (877) 358-0202
Fax: (858) 495-5080
Email: tony.potter@sdcounty.ca.gov

Serving: San Diego, CA

5. Legal Assistance for Seniors
Janet Van Deusen
HICAP Program Manager
464 7th Street
Oakland, CA 94607
Phone: (510) 839-0393
Fax: (510) 987-7399
Email: jvandeusen@lashicap.org

Serving: San Francisco/Oakland/ Alameda County CA

Appendix VI

Health Assistance Partnership

The Health Assistance Partnership (HAP), which is affiliated with Families USA, is a resource for government-run and nonprofit consumer health assistance programs that help health care consumers better understand and secure their health care rights. HAP works with the California HICAPS and ombudsman programs serving Medicare, Medicaid, and privately insured consumers as well as programs working with uninsured clients. HAP focuses on providing technical help and training for, information to, and networking among to health assistance programs.

Although HAP is not strictly a California resource, we cite it here because it is an excellent resource for government-run and nonprofit consumer health assistance programs in California including the HICAPs, the Health Consumer Alliance, and the California Department of Managed Care. HAP provides at no cost technical assistance, professional development, and training opportunities to consumer health assistance programs around the country. Their website provides comprehensive and understandable information for health professionals about the MMA including information about assistance for low-income beneficiaries and long-term care residents, a step-by-step guide for enrollment, and explanation of the Medicare Part D appeals process.

(<http://www.healthassistancepartnership.org/site/PageServer?pagename=MedicareRxDrugBill>)

HPA's California-specific activities include:

- Working closely with Medicare policy advocates at California Health Advocates, National Senior Citizens Law Center, NHeLP, the Health Consumer Alliance and the state and local HICAP offices to understand the MMA, how it will affect Californians on Medicare, and what advocates can do to empower Californians to reach informed decisions and become strong self-advocates.
- Engaging many HICAP, Long-Term Care Ombudsman, legal services and Health Consumer Alliance staffers on our monthly conference calls about Medicare Part D and promoting use of their website tools. Californians have participated in HAP's 3 national conferences.
- As a result of California advocates participating in HAP conference calls and conferences and using its website, HAP has been able to test many of its tools and other materials in California.
- Hap maintains ongoing communications with the California HICAPs, California Health Advocates and the State Department of Aging about how best to improve the infrastructure and funding of the HICAP network.
- HAP has been asked to train legal services and HICAP personnel in southern California on Part D plan formularies and appeals in order to facilitate creation of a corps of

advocates to assist Part D enrollees who may not be able to access their prescribed medications through their Part D plans.

HAP's California partners include:

The Actor's Fund of America
Artists' Health Insurance Resource Center

5757 Wilshire Boulevard
Suite 400
Los Angeles, CA 90036
Phone: 323-933-9244
Website: <http://www.ahirc.org/>

Provides health insurance information and assistance to members of the arts and entertainment communities.

The Health Consumer Alliance (Main Office)

2639 South La Cienega Boulevard
Los Angeles, CA 90034
Phone: 310-204-4900
Email: hca@healthlaw.org
Website: <http://www.healthconsumer.org/>

Serves low-income residents with health care problems in [El Dorado](#), [Fresno](#), [Kern](#), [Los Angeles](#), [Orange](#), [Placer](#), [Sacramento](#), [San Diego](#), [San Francisco](#), [San Mateo](#), and [Yolo](#) counties.

The Health Insurance Counseling and Advocacy Program (HICAP)
California Department of Aging

5380 Elvas Avenue, Suite 104
Sacramento, CA 95819
Phone: 916-231-5110 (national number)
Toll-Free: 1-800-434-0222
Website: <http://www.cahealthadvocates.org>

Educates and assists Medicare beneficiaries, those eligible for Medicare, and caregivers about Medicare, Medicaid, Medigap, pharmacy assistance programs, and other issues related to health insurance benefits.

Department of Managed Care
California HMO Help Center

980 Ninth Street, Suite 500
Sacramento, CA 95814-2725

Toll-Free: 1-888-HMO-2219 (toll-free)
TDD: 1-877-688-9891
Website: <http://www.hmohelp.ca.gov/gethelp/>

Serves residents enrolled in HMOs and Blue Shield PPOs (serves mostly privately insured consumers); helps resolve problems with medical care, prescriptions, preventive testing, and mental health services; assists with questions regarding the complaint process and health care rights; provides education.

Medi-Cal Managed Care Office of the Ombudsman
Department of Health Services

1501 Capitol Avenue, MS-4412
Sacramento, California 95814
Phone: 1-800-896-2512 TTY
1-888-896-4042
Website: <http://www.dhs.ca.gov/mcs/mcmcd/>

Serves California residents with Medicaid (Medi-Cal)

Medi-Cal Mental Health Ombudsman Services
Department of Mental Health

1600 Ninth Street, Room 130
Sacramento, California 95814
Phone: 916-654-3890
Toll-Free: 800-896-4042 (only in California)
TTY: 1-800-896-2512
Website: <http://www.dmh.cahwnet.gov/specialprograms/ombud.asp>

Serves residents Medicaid who have mental health concerns

Appendix VII

Health Consumer Alliance

The Health Consumer Alliance (HCA) is a state-wide partnership of consumer assistance programs operated by community-based legal services organizations. Its common mission is to help low-income people obtain essential health care by: (a) helping consumers establish or maintain health coverage; and (b) ensuring that low-income consumers with health coverage get good access to essential services. HCA's local Health Consumer Centers operate in thirteen California counties—Alameda, El Dorado, Fresno, Imperial, Kern, Los Angeles, Orange, Placer, Sacramento, San Diego, San Francisco, San Mateo and Yolo—through nine district centers. Their catchment area serves more than three-fifths of California's poor.

HCA has taken a strong role in assisting low-income people understand and enroll in the Medicare Part D program. Initially, they supported through outreach, education, and application assistance enrollment in the MMA \$600 prescription drug subsidy. They are currently outreaching to low-income populations to sign up for the LIS. When the PDP plans are announced in November, they will be one of the only organizations surveyed to actually help low-income seniors choose an appropriate PDP through telephone hotline and counselor assistance.

HCA has a strong MMA education program that currently conducts 75 community forums per month, operates nine telephone hotlines that screen callers for MMA-related problems, and importantly, is publishing written and web-based consumer information brochures about the MMA in 13 languages: Armenian, Cambodian, Chinese, English, Farsi, Hmong, Korean, Laotian, Russian, Spanish, Tagalog, Thai, and Vietnamese. Their hotline counselors serve 1,000 people a month.

Their outreach efforts to minority populations are well targeted because they are population and culture specific. Outreach efforts to Hispanics in Los Angeles, for example, focus on utilizing popular Spanish-language talk radio programs; outreach efforts to Asians, in contrast, use small community events at local CBOs.

Each month, more than 6,300 low-income consumers and community organization staff members attend education and outreach events that they sponsor. These events are geared to many minority populations including Latinos, Asians and Pacific Islanders, African-Americans, and people with disabilities, as well as to various health, law, community, women's, and social service groups.

The Health Consumer Alliance Partners are:

Fresno County: Central California Legal Services, Inc.
Fresno Health Consumer Center
1999 Tuolumne St., Suite 700
Fresno, CA 93721
800.300.1277

Imperial County: California Rural Legal Assistance
Health Consumer Center of Imperial Valley
449 Broadway Street
El Centro, CA 92243
760-353-0220

Kern County: Greater Bakersfield Legal Assistance
Kern Health Consumer Center
615 California Ave.
Bakersfield, CA 93304
661-321-3982

Los Angeles County: Neighborhood Legal Services of Los Angeles County
Health Consumer Center of Los Angeles
13327 Van Nuys Blvd.
Pacoima, CA 91331
800.896.3203

Orange County: Legal Aid Society of Orange County
Orange County Health Consumer Action Center
902 N. Main St.
Santa Ana, CA 92701
800.834.5001 or 714-571-5200

Sacramento,
El Dorado, Placer &
Yolo Counties Health Rights Hotline
519 12th St.
Sacramento, CA 95814
888.354.4474 or 916.551.2100

San Diego County: Legal Aid Society of San Diego
Consumer Center for Health Education and Advocacy
1475 6th Ave., 4th Fl.
San Diego, CA 92101
877.734.3258

San Francisco
& Alameda Counties Bay Area Legal Aid
Community Health Advocacy Project
50 Fell St., 1st Fl.
San Francisco, CA 94102
415.354.6360 (San Francisco) or 510.250.5270 (Alameda)

San Mateo County Legal Aid Society of San Mateo

Health Consumer Center of San Mateo County
521 East 5th Ave.
San Mateo, CA 94402
800.381.8898 or 650.558.0915, 650.558.0786(TDD)

Support Centers: National Health Law Program
2639 South La Cienega Blvd. Los Angeles, CA 90003
310-204-6010

Western Center on Law and Poverty
3701 Wilshire Blvd., Suite 208
Los Angeles, CA 90010
213-487-7211

Appendix VIII

Health Access California

Health Access California (HAC) is a statewide advocacy organization dedicated to achieving quality, affordable health care for all Californians. Health Access works with a broad coalition of more than 200 member organizations representing communities of color, immigrants, people with disabilities, children, seniors, people of faith, labor, and working families. One of the strengths of the organization is that it works at both the grassroots and senior policy levels to advocate for substantive reforms. They maintain offices in Oakland, Sacramento, and Los Angeles.

HAC's MMA implantation efforts include:

- Educating their constituencies about the MMA program and providing resources to help them
- Encouraging advocacy and policy change around the MMA; advocating for state wrap-around to compensate for any benefits covered under state MediCal but not covered under Medicare Part D
- Sponsoring AB1359, which will ensure that new drug benefits through the MMA will be at least as good as existing California program under MediCal;

Specifically, HAC advocates for the following:

- Augmenting the Governor's Budget to include an Emergency Coverage plan for the Medicare covered drugs for first two years of the Part D program to ensure continuity of care for dual eligible beneficiaries. (i.e. emergency coverage pending an appeal or exception process);
- Augmenting the Governor's Budget to provide assistance for dual-eligible beneficiaries with new Co-Pays and Premium burdens;
- Urging the California Legislature to accept the Governor's proposal to continue providing drugs now covered by the Medi-Cal Program for dual eligible beneficiaries where federal matching funds are available as those classes of drugs will not be covered by Medicare;
- Urging the California Legislature to accept the Governor's proposal to provide funds for outreach activities as follows: (1) to assist individuals with enrollment problems; (2) for targeted outreach to dual eligible beneficiaries about changes to the program that are specifically targeted to reach low-income individuals who are aging and have disabilities; and (3) using accessible formats that are easily understandable and accessible, including to individuals with no or limited English proficiency, limited literacy, cognitive impairments, physical limitations and limited access to the internet.

Health Access officials did not want to discuss the organization's funding or spending, and did not respond to repeated requests for specific information about its members.

Appendix IX

California Health Advocates; HICAPs

[California Health Advocates](#) (CHA) is a nonprofit organization dedicated to education and advocacy efforts on behalf of California Medicare beneficiaries. CHA promotes directly the work of the Health Insurance Counseling and Advocacy Program (HICAP) projects serving 4.1 million Medicare beneficiaries of all ages throughout California. CHA provides statewide technical training and support to local HICAP professional staff and volunteer counselors, with a special focus on dual eligibles. In addition, CHA sponsors and supports the California Medicare Coalition (see Appendix IX)

In addition, CHA publishes the [CalMedicare.org web site](#) with the support of the California Health Care Foundation.

Mission Statement: Through leadership, communication, and partnerships, California Health Advocates is dedicated to achieving and sustaining timely, accurate, and responsive education and advocacy efforts for California Medicare beneficiaries and the pre-retirement population.

Vision

To be a reliable and responsive source of accurate and easy-to-understand information about California Medicare, related health insurance coverage, and long-term care insurance.

Guiding Principles

CHA is dedicated to developing, promoting, and coordinating educational and other efforts to support HICAP, policymakers, and the public. CHA shall encourage, sponsor, and conduct research into issues affecting HICAP and the public regarding health benefits, services, and long-term care.

Values

California Health Advocates is committed to keeping California Medicare beneficiaries and their families up-to-date with accurate information, online and on paper, about Medicare, related health care coverage, and long-term care insurance, and by providing high-quality community education and professional training opportunities.

The Health Insurance Counseling and Advocacy Program (HICAP)

The Health Insurance Counseling and Advocacy Program (HICAP) is a volunteer-supported program that provides assistance with Medicare and health insurance problems for those on or eligible for Medicare. HICAP provided education and counseling to Medicare beneficiaries and training for HICAP counselors. Through a telephone hotline and local statewide offices, HICAP provides unbiased information to help Medicare beneficiaries enroll in Medicare programs and the LIS, and launch appeals. HICAP Counseling Services are provided by volunteer counselors

registered by the California Department of Aging. The California Department of Aging administers HICAP services. HICAP services are available in every county in California.

HICAP assistance is free and includes community education services and individual counseling. HICAP counselors provide information and counseling on:

- Medicare beneficiaries' rights as health care consumers
- Medicare benefits and rights, including how to appeal denials of coverage
- Legal help and representation at Medicare appeals and administrative hearings
- Private Medicare supplemental insurance (Medigap) coverage
- Health Maintenance Organizations (HMOs) or Medicare Advantage Plans (previously known as Medicare+Choice Plans)
- Long Term Care Insurance

The HICAP website provides information in English and Spanish only about the MMA and the availability of assistance for people with low incomes.

<http://www.cahealthadvocates.org/facts/index.html>

Because HICAP offers the services of one-on-one counseling, is conveniently located in every California county, and is charged with the responsibility of providing information about Medicare to beneficiaries, it will be a primary source of information about Part D and the LIS, and a logical point of access for Medicare Part D applicants.

However, because HICAP does not sell, endorse, or recommend any specific health insurance, it is forbidden by law to: provide recommendations to Medicare beneficiaries about specific PDPs, recommend which PDP beneficiaries should choose, or help Medicare beneficiaries fill out applications for a specific PDP. Cognizant of this major limitation in the provision of their services, HICAP is endeavoring to provide comparison tools to help clients make their own decisions (see Appendix XX, Enrollment Plans). However, as of 8/31/05, a HICAP official could not say how this will happen. Although there has been a lot of discussion on the state and national levels about how to assist beneficiaries choose a PDP, the HICAPs have not yet received any guidance about doing it.

We surveyed the Part D implementation activities of four important HICAP offices: San Francisco, Los Angeles, Alameda, and Sacramento. Some specific outreach and education efforts of the local HICAP offices include the following:

Legal Assistance for Seniors/HICAP Alameda

- Services 160,000 Medicare beneficiaries in Alameda County
- With funding through ABC, conducted targeted outreach for the Medicare discount card in Oakland.
- Sponsored tri-county conference on Part D (SF, Alameda, SM) targeted to provide education/training to disability providers
- Funding is pending from ABC (\$25,000 for San Francisco; approx \$8,000 for Oakland) for targeted media outreach and special events to outreach to low-income (150% poverty level) seniors.

- They have provided additional training to HICAP counselors on how to help fill out LIS application.
- Will try to help clients make decisions that can lead them to a plan. They will provide comparison tools to help client navigate to make their own decisions. They will help those who can't navigate the web to figure out which plan covers their medications. They don't know how this will happen yet. There has been a lot of discussion on state and national level but no guidance.

Center for Healthcare Rights/HICAP LA

- Provides advocacy, direct services (legal services and HICAP), and advocacy
- Focuses on MMA education, outreach, counseling, and legal assistance for 1 million Medicare beneficiaries in LA County.
- Reaches a broad spectrum of vulnerable, poor, and ethnic/racial minority populations (there are 1 million Medicare beneficiaries in LA Co) by providing education (in-service trainings) to social service and aging service providers (including LTCOP and case management programs) have been targeting Latino, African Americans, institutionalized, and low income seniors
- Provides in-house translation services in Tagalog, Spanish, Korean, Vietnamese. (Also uses contracted interpreter services in Russian and Armenian when presenting in communities).
- Eighty percent of total agency budget of \$1.2 mil. is devoted to Medicare Part D direct services and policy efforts. (Policy work funded by CA Wellness Foundation)
- Will try to work around CMS's prohibition of choosing individual PDPs for clients by developing a process that considers what is important to clients' personal and financial situation and then identifying three alternative choices (This is similar to what the agency did with Medicare discount drug card.)
- As a direct service provider, the bulk of agency time has been devoted to preparing for requests for assistance.

HICAP Sacramento

- Recipient of TCE grant that focuses on:
 - (i) policy issues affecting low-income individuals (including dual eligibles) in California, with the purpose of providing information (through issue papers, alerts and briefs), education and a series of trainings for the advocacy community and service providers (including legal services agencies, HICAPs Health Consumer Alliance and others)
 - (ii) providing support for agencies that will be counseling (and enrolling?) Medicare beneficiaries
 - (iii) working in partnership with NSCLC and to a lesser degree with Center for Medicare Advocacy
 - (iv) geographic targeting based on "where the need arises and requests to give presentations" –
 - (v) meeting regularly with CMS and State Department of Health Services to address issues related to low-income individuals to effect policy

(vi)planning a statewide conference geared towards LI advocates for October 18th to provide training on Part D to be held in LA

- Organization provides support to network of HICAPs
- Received California HealthCare Foundation grant to sponsor California Medicare Coalition, which seeks to bring together broader group of organizational players (state, federal, CBOs) to advocate more broadly for Medicare policy-.00`

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HICAP offices are located in every county of California

- | | | | |
|---------------------------------------|--------------------------------------|--|-------------------------------------|
| ○ <u>Alameda</u> | ○ <u>Kings</u> | ○ <u>Placer</u> | ○ <u>Shasta</u> |
| ○ <u>Alpine</u> | ○ <u>Lake</u> | ○ <u>Plumas</u> | ○ <u>Sierra</u> |
| ○ <u>Amador</u> | ○ <u>Lassen</u> | ○ <u>Riverside</u> | ○ <u>Siskiyou</u> |
| ○ <u>Butte</u> | ○ <u>Los Angeles</u> | ○ <u>Sacramento</u> | ○ <u>Solano</u> |
| ○ <u>Calaveras</u> | ○ <u>Madera</u> | ○ <u>San Benito</u> | ○ <u>Sonoma</u> |
| ○ <u>Colusa</u> | ○ <u>Marin</u> | ○ <u>San Bernardino</u> | ○ <u>Stanislaus</u> |
| ○ <u>Contra Costa</u> | ○ <u>Mariposa</u> | ○ <u>San Diego</u> | ○ <u>Sutter</u> |
| ○ <u>Del Norte</u> | ○ <u>Mendocino</u> | ○ <u>San Francisco</u> | ○ <u>Tehama</u> |
| ○ <u>El Dorado</u> | ○ <u>Merced</u> | ○ <u>San Joaquin</u> | ○ <u>Tuolumne</u> |
| ○ <u>Fresno</u> | ○ <u>Modoc</u> | ○ <u>San Luis Obispo</u> | ○ <u>Trinity</u> |
| ○ <u>Glenn</u> | ○ <u>Mono</u> | ○ <u>San Mateo</u> | ○ <u>Tulare</u> |
| ○ <u>Humboldt</u> | ○ <u>Monterey</u> | ○ <u>Santa Barbara</u> | ○ <u>Ventura</u> |
| ○ <u>Imperial</u> | ○ <u>Napa</u> | ○ <u>Santa Clara</u> | ○ <u>Yolo</u> |
| ○ <u>Inyo</u> | ○ <u>Nevada</u> | ○ <u>Santa Cruz</u> | ○ <u>Yuba</u> |
| ○ <u>Kern</u> | ○ <u>Orange</u> | | |

Appendix X

California Medicare Coalition

Two years ago, CHA was asked by CMS to set up a project to succeed the defunct Beneficiary Advisory Committee (BAC) in Northern and Southern California. CMS envisioned a new coalition that would bring together many diverse organizations and beneficiary interests. The resulting California Medicare Coalition (CMC) is intended to stimulate a coordinated statewide effort to organize community events, local workshops and educational meetings with the aim of improving outreach to and education about the MMA for hard-to-reach, underserved populations in California, particularly those with access barriers due to language, literacy, location and culture.

The purposes of the CMC are (1) to help bridge the gap in information and coordination to enhance the delivery of information about Medicare and improve access to health care services; and (2) to serve specifically as a central resource for information about and coordination of MMA outreach and implementation activities.

The CMC intends to provide a place for individuals and agencies serving and advocating on behalf of Medicare beneficiaries to meet together and help each other keep informed about the latest changes in health care financing arrangement for all Medicare beneficiaries.

In addition, CMC sponsors the CalMedicare.org web site, which gives accurate, unbiased information about Medicare in California.

The CMC is supported by a \$579,418 California Health Care Foundation grant to California Health Advocates, "Improving the Decision-Making Support Available to California Medicare Consumers," for supporting Medicare consumer decision making, with a focus on Medicare Part D, by building the California Medicare Coalition, organizing educational events for consumers and their intermediaries, and developing information resources for state policymakers, consumers, and Medicare consumer intermediaries.

Currently, CMC is loosely organized, has little infrastructure, and no formal membership. However, CHA has provided us with their informal membership roster, which follows. The membership of CMC represents a very diverse group of people and organizations that is proving to be "tricky" to keep together because they represent disparate interests, and have different perspectives about and strategies for implementing the MMA. Nevertheless, getting these interests together at the same table is one of the program's central tasks.

The California Medicare Coalition will hold four meetings in California in October and December of 2005, including two meetings on October 5 and December 7 in Southern California, and two meetings in Northern California on October 12 and December 14.

Appendix XI

World Institute on Disability (WID)

The World Institute on Disability (WID), which is headquartered in Oakland California, is a nonprofit research, public policy and advocacy center dedicated to promoting the civil rights and full societal inclusion of people with disabilities. The institute provides comprehensive MMA benefits and eligibility information for people with disabilities through its California Work Incentives Initiative (CWII) and on its website. WID focuses about 35% of its total efforts and budget on the CWII.

Given that 500,000 of California's 4 million Medicare beneficiaries are under 65 and disabled, that 40% of them have cognitive impairments, and that they have particularly high rate of drug utilization, it is critical that the special needs of this population be addressed. Since 2003, CWII has done extensive analysis of the MMA and its potential impact on people with disabilities.

In November 2004, CWII refocused its Medicare training materials to educate on the new Medicare Part D rules. The new CWII training materials, Medicare 2005, the Parts and the Players, have been presented at 23 Medicare Part D trainings or presentations in nine California counties. The target audiences are cross agency and community based non profit organization service providers, totaling over 800 participants who work primarily with people with disabilities under 65.

CWII held training and outreach meetings about Medicare Part D throughout August and on September 22 will co-produce with California Health Advocates a major Los Angeles outreach event for beneficiaries, family members, nonprofit benefits planners, nonprofit community-based organizations, county welfare office staff, and the general public. One-third of California's dual eligibles live in L.A. county.

To address the growing concerns and questions that beneficiaries are having about these drug benefit changes, CWII developed and tested statewide a *Medicare Beneficiary Planning Tool*, which contains essential Medicare Part D rollout information and timelines, and a workspace for Medicare beneficiaries to organize benefits and medical information.

CWII is distributing 63,000 copies of the Tool (including alternate formats) free to its DB101 outreach contractors and to any non profit, faith based or educational organization ordering them, until supplies run out. The downloadable, printer friendly formats of the Tools are on www.db101.org . The website also includes a link to access HICAP counselors.

Appendix XII

National Asian Pacific Center on Aging (NAPCA)

Although this is a nation-wide program, NAPCA partners with 19 California agencies that are all conducting MMA-related implementation activities. They were unable to tell us the amount of monies committed to their California work, or the percentage that it represents of their work nationally.

In California, NAPCA focuses most of its efforts in the San Francisco Bay Area and in LA and Orange Counties, where most Asian elders live. Their most important work related to the MMA is translating MMA program information/materials into 12 different languages for Asian/Pacific Islanders.

The NAPCA National Toll-free Multilingual Helpline Center is the only national helpline Asian and Pacific Island (API) elders can call to obtain direct bilingual enrollment assistance and access to translated information about Medicare Prescription Drugs Benefit without the need to navigate through intimidating English voicemails, phone menus, or operators. They sponsor telephone hotlines in English and three Asian languages: Chinese, Vietnamese, and Korean. Since October 2004, the NAPCA Helpline has responded to nearly 15,000 calls and assisted over 2000 elders to enroll in the transitional assistance program under the Medicare prescription drug discount card program. Helpline counselors walk beneficiaries through the enrollment process. Elders that call the Helpline are sent their language-specific forms designed by NAPCA to screen their eligibility. Helpline staff then complete these forms for the elders over the phone. Once an elder was found to be eligible, Helpline staff helped identify the best discount card programs for the elder and enrolled them in the card of their choice by filling out the enrollment form for the elder to sign or by enrolling online. When the enrollment for Medicare Prescription Drugs Coverage (Part D) begins, NAPCA expects to provide the same level of assistance to API seniors in accessing the LIS and choosing an appropriate PDP.

NAPCA's California partners include 19 local community-based organizations in the San Francisco Bay Area, Los Angeles, Garden Grove, Santa Ana, Long Beach, and Sacramento, which assist the following ethnic minority Asian populations: Korean, Chinese, Vietnamese, Laotian, Cambodian, Filipino, Thai, and Pacific Islanders, among others.

NAPCA-SCSEP-Los Angeles, 3407 W. 6th Street, Suite 800, Los Angeles, CA 90020

Self-Help for the Elderly, 407 Sansome Street, San Francisco, CA 94111-3122
(NAPCA Subcontractor)

Korean Center, 1362 Post St., San Francisco, CA 94109

Korean Community Center of East Bay, 4390 Telegraph Ave., Oakland, CA 94609

Family Bridges (old Oakland Chinese Comm. Council), 168 11th St. Oakland, CA 94607

Seton Senior Center (old Vietnamese Senior Center of EB), 211 B Foothill Blvd., Oakland, CA 94606

Vietnamese Comm. Development, Inc., 2319 International Blvd., Oakland, CA 94601

Lao Family Community Development, Inc., 1551 23rd Avenue, Oakland, CA 94606

Cambodian Community Development Inc., 1900 Fruitvale Ave. #3b, Oakland, CA 94601

Korean Health Education, Information, & Research Center (KHEIR) 545 S. Gramercy Place, Los Angeles, CA 90020

Sunflower Adult Day Health Center, 220 Winchester Place, San Gabriel, CA 91776

Sunny Day ADH Center, 10530 Lower Azusa Rd., El Monte, CA 91731
Thai Health & Information Services, Inc., 1717 N. Gramercy Place, Hollywood, CA 90028

Federation of Filipino American Assoc., 2125 Santa Fe Ave., Long Beach, CA 90810

Guam Communication Network, 4201 Long Beach Blvd., Suite 2, Long Beach, CA 90807

BP SOS, 9550 Bolsa Ave., Suite 201, Westminster, CA 92683-5944

Vietnamese Community of Southern Calif., 13139 Harbor Place, Garden Grove, CA 92843

OC Korean Health Information & Education, 9636 Garden Grove Blvd., #20, Garden Grove, CA 92844

Asian American Senior Citizens Service Center (AASCSC), 850 N. Birch Street, Santa Ana, CA 92701 (NAPCA Subcontractor)

BP SOS, 5029 Stockton Blvd., Sacramento, CA 95820

Appendix XIII

The National Senior Citizens Law Center (NSCLC)

The National Senior Citizens Law Center advocates nationwide to promote the independence and well-being of low-income elderly individuals and persons with disabilities through litigation, and legislative and agency representation and assistance to attorneys and paralegals in field programs. NSCLC's functions vary with the needs of our clients. NSCLC maintains a national reputation for professional quality and successful advocacy.

In 2003, NSCLC took up the issue of elderly poor "dual-eligibles" caught between the Medicare and Medicaid systems. They have been at the forefront of advocates for low-income elderly, providing policy analyses, recommending improvements and, if need be, litigating to address systemic injustices at the federal and state levels. They are supporting the drive for a prescription drug benefit for low-income and other persons.

NSCLC stands up for the rights and interests of the poorest and most vulnerable elderly. NSCLC is the only national organization focusing specifically on issues affecting the elderly poor and disabled. Specifically, NSCLC:

- **advocates** for the elderly poor in legislative and administrative policymaking in Washington D.C.
- **litigates** principally on access and fair procedure issues having broad impact, especially on poor and low-income persons
- **trains, informs and assists** local advocates throughout the nation so that older persons have the best possible representation for the broadest possible range of cases.

NSCLC receives grants from foundations and government agencies (the Federal Administration on Aging, acting under the Older Americans Act) as well as donations from private individuals and law firms.

They maintain an office in Oakland to monitor and discuss California activities, and a page on their website is devoted to California news and commentary on Medicare Part D in California, which has an excellent slide show about the MMA in California.

They publish on their website excellent issues papers on areas of the MMA. Articles from NSCLC's [Washington Weekly](#):

- [CMS Releases Medicare Drug Premium Amounts](#) (Updated August 30, 2005)
- [Educational or Promotional? The Premature Marketing of Medicare Part D](#) (August 5, 2005)
- [Navigating the Medicare Part D Appeals Process](#) (July 22, 2005)
- [Medicare Part D: Your Drug Plan Can Stop Providing Your Medication](#) (July 8, 2005)

- [Medicare Part D: Who Can Enroll, Disenroll, or Appeal on Behalf of Beneficiaries](#) (July 1, 2005)
- [Federal Agencies Notify Beneficiaries, Promote Assistance for Medicare Part D Drug Benefit](#) (June 3 & 10, 2005)

The NSCLC has developed excellent training materials and PowerPoint presentations around critical issues of the MMA and implementation of the law, which are available at its website: http://www.nsclc.org/issues_health_medicareD.html.

Appendix XIV

Faith-Based Efforts: CARxE/United Methodist Association

CARxE (Coalition to Advance Prescription Drug Education) is a nonprofit coalition of faith-based organizations, retirement communities, consumer advocates, community ministries, and social welfare organizations dedicated to providing comprehensive, personal, and accurate education and enrollment assistance for Medicare Part D beneficiaries. CARxE is a coordinated response by prominent health industry companies, consumer advocates, faith-based congregations and social welfare organizations to educate and enroll seniors for Part-D benefits.

A CAREX program, *Serving America's Seniors* (SAS), will develop an extensive network of volunteers through faith-based organizations to enroll seniors the new Medicare Part-D Drug Benefits Program with person-to-person contact and education. Its faith-based outreach is funded by the United Methodist Association. This outreach effort is being funded and coordinated by Mearle Griffith, President/CEO of the United Methodist Association, a network of nearly 400 Health and Welfare Ministries within The United Methodist Church. Dr. Griffith is also President /CEO of the Coalition to Advocate Prescription Drug Education (CARxE).

The network of faith-based organizations includes, but is not limited to, congregational partners in mainline denominations, Senior Health and Welfare Ministries within faith-based associations, Parish Nurses, and myriad senior-serving Community Service Ministry Organizations and related associations who serve seniors. There are ongoing discussions with approximately 30 denominations.

Their website states that this alliance of faith-based organizations has the potential of reaching America's nearly 325,000 congregations/synagogues/mosques of all faith traditions and sets in place a mechanism to invite, recruit, train and utilize volunteers from more than 150 million congregants across this country, based on membership statistics from the 2005 Yearbook of American Churches.

The outreach plan reaches out across two venues: [a] congregations and community service ministries, and [b] health and welfare associations.

This Program will provide an extensive call for volunteers and volunteer coordinators. It will include extensive communication with local pastors, agency executives, and denominational leadership to be the most massive recruitment efforts possible. This will be combined with an extensive local, regional and national communication plan within the national media, church media, and local media in locations where congregations are participating. A national kickoff for the program will be held in Houston, Texas on August 18.

CARxE provides on their web site impartial and neutral information about the Medicare Part D program and a narrated slide show explaining Part D coverage. In addition, the website will provide through its "Benefits Gateway" a tool for comparing the costs, benefits, and formularies

of all the available drug plans in each of the 34 designated Medicare Part D regions, which is intended to help beneficiaries choose and enroll in a PDP. This software uses the same technology that drives the Medicare web site for Part D plan and cost comparisons.

- **Currently**, the Gateway assists learning about the Medicare Prescription Drug Program, and how beneficiaries can benefit from it.
- In **October**, when Medicare announces the actual drug plans, this Gateway will help beneficiaries determine which plans will serve their particular needs.
- Beginning on **November 15, 2005**, beneficiaries can enroll in the plan of their choice using the *Gateway*.

United Methodist Association

United Methodist Association is a national association of United Methodist-related ministries and individual professionals concerned about the quality of health care in a faith-based setting. Headquartered near Dayton, OH the United Methodist Association serves nearly 400 health and human service organizations and professionals nationwide. These ministries respond to the needs of nearly ten million persons annually.

DestinationRx

DestinationRx is the number one consumer site for drug comparison. It features a decision support tool with point of sale messaging and transaction processing capabilities. Their clients include AARP, American Federation of Teachers, Centers for Medicare and Medicaid Services (CMS), DrugStore.com, EntirelyPets.com, HomeMed.com, RxUSA, United Healthcare, United Methodist Association, and Wal-Mart.

Specific DestinationRx Product/Service Bundles include:

- **Price Comparison:** DestinationRx provides pre-packaged price comparison services for prescription drugs based on NDC numbers, drug name, dosage, quantity, package size or other parameters. Data is normalized to ensure comparability from multiple sources. Comparison services can be provided as one-off reports for fairness opinions, all the way through private-labeled ASP deployment.
- **Decision Support:** DestinationRx provides ready-made Decision-Support tools for government payer/beneficiary programs and systems. These easy-to-use tools provide quick answers for those seeking price-efficacy information for their drug and treatment regimens
- **Therapeutic Equivalents:** DestinationRx has developed rebate-agnostic equivalency technology for branded and generic drugs on a dosage-equivalent basis. This can be tuned to specific formularies or broadened as the needs require.
- **Enrollment Technologies:** DestinationRx has a proprietary set of tools that help manage online enrollment including custom interfaces to help enrollment for those with or without Internet access. These tools are modularized to ensure that customization with customer needs is quick and easy.

Appendix XV

The National Council on the Aging (NCOA)

Founded in 1950, The National Council on the Aging is a national network of organizations and individuals dedicated to improving the health and independence of older persons and increasing their continuing contributions to communities, society and future generations.

Its 3,800 members include senior centers, adult day service centers, area agencies on aging, faith congregations, senior housing facilities, employment services, and other consumer organizations.

NCOA also includes a voluntary network of more than 11,000 leaders from academia, business and labor who support our mission and work.

After reviewing the details of the MMA, The National Council on the Aging decided to support it with reservations. In the final analysis, they found that the provision of prescription drugs to the LIS-eligible population, even though the process is complex and cumbersome, outweighed the limitations of the law.