

SUBSTANCE ABUSE AND MENTAL HEALTH
SERVICES ADMINISTRATION

NATIONAL ADVISORY COUNCIL

39th Meeting

Teleconference

Wednesday,
April 26, 2006

Sugarloaf Mountain Room
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, Maryland

IN ATTENDANCE:

Chairperson

Charles G. Curie, M.A., A.C.S.W.
Chair/Administrator, SAMHSA
Rockville, MD 20857

Executive Director

Daryl W. Kade, M.A.
Executive Director, SAMHSA National Advisory Council
Associate Administrator for Policy, Planning,
and Budget, SAMHSA
Rockville, MD 20857

Executive Secretary

Toian Vaughn, M.S.W.
Executive Secretary, SAMHSA National Advisory Council
Rockville, MD 20857

Members

James R. Aiona, Jr.
Lieutenant Governor
Executive Chamber
Hawaii State Capital
Honolulu, HI

Gwynneth A. E. Dieter
Mental Health Advocate
U.S. Embassy Belize

Faye Annette Gary, Ed.D., R.N.
Professor, Case Western Reserve University
Frances Payne Bolton School of Nursing
Cleveland, OH

Diane Holder
President
UPMCC Health Plan
Pittsburgh, PA

IN ATTENDANCE:

Barbara Huff
Consultant
The Federation of Families for Children's Mental Health
Wichita, KS

Thomas A. Kirk, Jr., Ph.D.
Commissioner
Department of Mental Health and Addiction Services
Hartford, CT

Theresa Racicot
Former First Lady of Montana
Arlington, VA

Kenneth D. Stark
Director
Division of Alcohol and Substance Abuse
Department of Social and Health Services
Olympia, WA

Kathleen Sullivan
Journalist
Rancho Mirage, CA

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1 P R O C E E D I N G S (2:04 p.m.)

2 MS. KADE: I'm Daryl Kade, director of policy,
3 planning, and budget here at SAMHSA. I want to go through
4 some housekeeping rules for the conference. I will be
5 opening the meeting with a roll call, and hopefully by that
6 time Mr. Curie will be available to present his opening
7 remarks on the Medicare prescription drug benefit.

8 Following his remarks, Dr. Anita Everett,
9 SAMHSA's senior medical advisor, will present an update on
10 SAMHSA's efforts on education and outreach as well as
11 SAMHSA's activities.

12 Dr. Everett will be followed by Dr. Jeffrey
13 Kelman, chief medical officer at the Centers for Medicare
14 and Medicaid Services, who will provide an update on the
15 progress of CMS' Medicare prescription drug program and an
16 overview of their outreach and education campaigns.

17 After the presentations, we will open the
18 meeting for discussion by Council members. The session
19 will be constructed in the following manner. Members will
20 be called in alphabetical order. We have allowed 60
21 minutes for the first round of discussion. Each member
22 will have three minutes -- three minutes -- to ask one
23 question or provide one comment. Staff and presenters will
24 have three minutes to respond, and if time permits we will
25 begin a second round of questions and answers.

1 We will open up the phone lines for public
2 comments at approximately 3:50 p.m. The public may have
3 submitted their comments prior to the meeting. The public
4 is also welcome to provide comments during the meeting
5 electronically at samhsanac@samhsa.hhs.gov or by notifying
6 TaRaena Yates in the Seneca Room.

7 Members of the public must remain on the line
8 during the public comment period if they wish their
9 comments to become a part of the record as is consistent
10 with SAMHSA NAC's practice. Only those comments received
11 by 3:50 will be accepted.

12 All participants are asked to conduct their
13 call from a quiet room. The use of cell phones, speaker
14 phones, cordless phones, and headsets is strongly
15 discouraged, since sometimes these devices can cause static
16 and additional noise. We ask that you use a landline
17 phone.

18 We ask participants to identify themselves each
19 time they speak. For example, "This is Jean from XYZ. I'd
20 like to make a comment."

21 Council members are reminded to mute internal
22 office conversations.

23 I am happy to say that Mr. Curie has just
24 joined us, and what I can do is call the roll call, and
25 then lead right into Mr. Curie and his opening remarks.

1 So with that, I wanted to verify who is on the
2 conference call. Lieutenant Governor Aiona?

3 MR. AIONA: Here.

4 MS. KADE: Ms. Dieter?

5 MS. DIETER: Yes, I'm here.

6 MS. KADE: Dr. Gary?

7 DR. GARY: Here.

8 MS. KADE: Ms. Holder?

9 MS. HOLDER: Here.

10 MS. KADE: Ms. Huff?

11 (No response.)

12 MS. KADE: Dr. Kirk?

13 DR. KIRK: Here.

14 MS. KADE: Mr. Lewis?

15 (No response.)

16 MS. KADE: Ms. Racicot?

17 MS. RACICOT: I'm here.

18 MS. KADE: Mr. Stark?

19 MR. STARK: I'm here.

20 MS. KADE: Ms. Sullivan?

21 MS. SULLIVAN: Here.

22 MS. KADE: And Ms. Bush was not able to
23 participate in the meeting because of scheduling conflicts.

24 I'd like to welcome co-chair Lieutenant
25 Governor "Duke" Aiona and the other Council members, and I

1 will give the microphone to Mr. Curie.

2 MR. CURIE: Well, thank you, Daryl, and I'll
3 say good day to everybody since it's the morning in some
4 places and the afternoon in other places. It's great to
5 have you all telephonically. Obviously, it would be great
6 to have you all here in person.

7 We are having this meeting and the topic of
8 this meeting at the request of the Council, because of the
9 keen interest the members of the Council have in the
10 Medicare new prescription drug coverage program, and
11 especially a focus on the impact on the people for whom
12 we're responsible, people with serious mental illness,
13 people with addictive disorders, and children with serious
14 emotional disturbances, and I want to thank the Council
15 members for their interest in this and leadership and input
16 as we move ahead.

17 First, let me say and remind everybody that
18 this is a critically important initiative to the
19 administration. The President and the Secretary have
20 personally spent much time focused on seeing this program
21 move ahead and succeed.

22 Dr. Mark McClellan, the Administrator of CMS
23 and my good colleague and friend, has just done I think a
24 tremendous job putting in hours. He and his staff have
25 virtually done what many thought might have been

1 impossible, and I'm sure some days they felt like it was.
2 They're still going through the process, but I just can't
3 say enough good things with what I've seen with the efforts
4 and work that they've put forward.

5 Again, the administration launched a broad
6 outreach campaign to educate seniors and disabled Americans
7 about Medicare's new prescription drug coverage program.
8 I'm pleased to say that more than 30 million Medicare
9 beneficiaries are now receiving the prescription drug
10 coverage. I might mention that that reaches a critical
11 benchmark for an estimate in the first year. Twenty-eight
12 to 30 million were anticipated, so that goal has already
13 been reached.

14 In March alone, more than 93 million
15 prescriptions were filled for these beneficiaries. So that
16 would average 3 million prescriptions a day.

17 Also, as you know, Medicare is a critical
18 safety net for Americans with disabilities. Millions of
19 Americans with developmental and physical disabilities,
20 mental illness, and HIV/AIDS count on Medicare. The good
21 news is Medicare's new drug coverage brings these citizens
22 secure coverage as well as modern medicine.

23 SAMHSA has had a role to play in educating and
24 supporting our consumers with accessing the full spectrum
25 of benefits available and we will continue to play that

1 role and press ahead. We're very pleased to have had the
2 opportunity to participate with CMS in this important
3 endeavor and outreach to the mental health and substance
4 abuse community.

5 Again, this is a new benefit that will enable
6 millions of Americans who previously had no access to
7 coverage of medication to obtain necessary medications at a
8 minimal cost.

9 We also know that for many Americans with major
10 mental illnesses, access to medication is an essential
11 element of successful recovery. Additionally, we know that
12 many cannot maintain sobriety and recovery from substance
13 abuse without the assistance of medications.

14 I also recognize that there have been some very
15 real issues associated with transition to this new benefit
16 in the mental health and substance abuse community. We
17 acknowledge that these challenges have been associated with
18 demands on consumer patience and on staff time. There have
19 been frustrations at many levels in our mental health and
20 substance abuse service delivery systems. Again, we've
21 worked closely with our partners in CMS to have confidence
22 that as the program matures, the needs of persons with
23 mental illness and substance abuse disorders will continue
24 to be well addressed.

25 I think specifically we need to recognize the

1 special consideration that's been provided for persons with
2 mental illness by CMS. This includes the mandate that all
3 or essentially all medications from the classes of
4 antidepressants, mood stabilizers, and antipsychotics be
5 included in every formulary that operates under this
6 program. CMS has developed and supported transitional
7 guidance which mandates that every person stable on a
8 particular combination of medications be allowed to remain
9 on that medication as this program is introduced. It's
10 been the intent from the very beginning as we've moved
11 ahead in partnership to assure that people do not lose
12 ground of the ground they've gained in addressing their
13 illness.

14 Again, we look forward to continuing our
15 relationship with Dr. McClellan as well as our special
16 guest today, chief medical officer of CMS, Dr. Jeffrey
17 Kelman. Thank you, Jeff, for joining us.

18 We think this solid partnership between SAMHSA
19 and CMS has facilitated a smoother transition for many
20 within the mental health and substance abuse community.

21 I'd also like to highlight a few of SAMHSA's
22 efforts to facilitate the transition. I believe that many
23 of you know I've been assisted in these efforts by my
24 senior medical advisor, Dr. Anita Everett, and I've invited
25 Anita to participate in today's call. In fact, she's

1 sitting right here next to me.

2 I just can't say enough good things about Dr.
3 Everett and what she has done in this process. I think she
4 has demonstrated strong leadership and also being a good,
5 committed, responsible partner to CMS as well as connecting
6 with our centers throughout SAMHSA to assure our
7 constituency groups' needs are heard.

8 In fact, I was pleased she was with me one day
9 in my old stomping grounds of Pennsylvania, where I was
10 just about a month and a half ago, where we were talking
11 about recovery. It was a major conference in Pittsburgh,
12 and I did have several consumers and family members come up
13 to me with concerns about this prescription drug program,
14 how it was being rolled out, how it was being engaged,
15 whether people were understanding it, problems people had
16 at their pharmacy, and that made me really pleased that
17 Anita was with me because I could pull Anita over and make
18 sure that she was hooked up with folks and was able to
19 facilitate a problem-solving process there.

20 I think that's indicative of what's been
21 occurring at different levels. I know states have been
22 strong partners in this process and are working with us.

23 Also, I think what makes Anita somewhat unique
24 in her participation in government at this level is she's
25 also a practicing community psychiatrist one day a week and

1 has personal firsthand experience in working with consumers
2 who have mental illnesses and that are Medicare
3 beneficiaries.

4 Anita and other lead SAMHSA staff have been
5 incorporating specific information about the prescription
6 drug benefit program also in numerous national public
7 appearances made over the last six months to mental health
8 and substance abuse groups.

9 Also, under my direction SAMHSA created an
10 email list of lead staff within each state department of
11 mental health and substance abuse. Information from CMS
12 and specific to areas of interest in mental health and
13 substance abuse also were forwarded to these groups, and
14 this has also created a venue through which exchange
15 between these state departments could then occur.

16 To date, we have 37 postings that have been
17 mailed out to this list and the list has been used, again,
18 to solicit and help resolve problems around access to long-
19 acting injections of antipsychotics as well as the impact
20 of co-pays for persons living in residential settings that
21 are not IMDs.

22 We also created a page on the SAMHSA website
23 dedicated to the Medicare Modernization Act which provides
24 specific information on prescription drug coverage and
25 preventative care services.

1 In addition to that outreach on the website, an
2 education and outreach partnership was created with several
3 national mental health advocacy groups through an
4 interagency funding agreement with CMS. I might mention
5 that these groups include the National Council for
6 Community and Behavioral Health Care, the National
7 Association of State Mental Health Program Directors, the
8 National Mental Health Association, and NAMI, the National
9 Alliance for the Mentally Ill. This enabled the
10 development and dissemination of widespread education
11 outreach materials to a wide range of state and local
12 affiliates of these organizations throughout the nation.

13 We've also reached out to the substance abuse
14 treatment field as well. Dr. Everett has participated in
15 regular meetings with national substance abuse treatment
16 organizations to provide education and outreach to answer
17 questions.

18 SAMHSA has also created opportunities for Dr.
19 Kelman and other CMS staff to present to mental health and
20 substance abuse provider groups, including the American
21 Psychiatric Association.

22 Printed materials. We have included an entire
23 edition of what we think is a widely read and widely
24 received SAMHSA newsletter that goes out, and that was
25 dedicated to the Medicare prescription drug benefit.

1 Actually, our newsletter is distributed to over 66,000
2 community, clinical, and administrative settings, and the
3 prescription drug benefit was promoted also through the
4 distribution of CMS Medicare Modernization Act brochures at
5 SAMHSA booth exhibits at national and regional meetings of
6 significance.

7 So it's been very much a part of our ongoing
8 materials that we include anytime we're doing an outreach
9 or anytime SAMHSA is being represented. We made that
10 commitment to that process and we'll continue to fulfill
11 that commitment.

12 We've also taken the critical step of educating
13 the SAMHSA staff through an all-staff SAMHSA in-service.
14 In addition, Dr. Everett has participated in a number of
15 regional forums and as a mental health expert in a number
16 of outreach calls to medical providers or to the CMS
17 Physicians Regulatory Issues Team, or PRIT.

18 All of these efforts merge I think into a clear
19 message. Millions of Americans will benefit from the
20 Medicare Modernization Act. We want to make sure that
21 especially happens for Americans that have been disabled by
22 mental illness or that have an addiction, and that these
23 Americans get services, they get the benefits they need and
24 deserve, and that they're able to take full advantage of
25 this new coverage, and that it will help continue

1 individuals to attain and sustain their recovery.

2 At this time, I'd like to invite Dr. Anita
3 Everett to make a few remarks, and then she'll introduce
4 Dr. Kelman from CMS.

5 Thanks, everybody, for your interest and your
6 participation today.

7 Anita?

8 DR. EVERETT: Thank you, Administrator Curie.

9 In addition to the specific items that
10 Administrator Curie has outlined, I want to emphasize and
11 assure you that SAMHSA will continue to be actively engaged
12 in working with CMS and our external partners to track
13 developments of this landmark program as it impacts and
14 assists members of the mental health and substance abuse
15 community.

16 Currently, as an example of the ongoing thing,
17 I meet on a weekly basis and as needed with representatives
18 of national mental health leadership here in Washington, we
19 meet with CMS as needed, which now is at the frequency of
20 every other week, and SAMHSA continues to send out postings
21 that are specific to the mental health and substance abuse
22 communities on developments of this benefit.

23 As Administrator Curie referenced, we value
24 consumer engagement. Consumers who have choices and are
25 engaged in the development of their own path to recovery

1 are more likely to minimize the often adverse impact that
2 mental illness or substance abuse can have. Medication is
3 often an important component of an individual's recovery
4 and the Medicare D benefit is a pathway for access to
5 medications for many.

6 As a reminder, what we are here to talk about
7 today is a benefit for Medicare recipients. To keep in
8 mind the scale of this benefit, there are about 300 million
9 Americans. About 42 million are Medicare beneficiaries.
10 The majority of Medicare beneficiaries are elderly. This
11 constitutes roughly 85 percent -- Dr. Kelman may be able to
12 give more exact figures -- and about 15 percent are
13 Medicare beneficiaries by way of a disability.

14 We don't know exactly how many Medicare
15 beneficiaries have a mental illness. We do know that
16 around 7 million Americans are dually eligible -- that is,
17 eligible for both Medicaid and Medicare -- and that as many
18 as 40 percent of these dually-eligible individuals are
19 likely to have some form of mental illness that's treated
20 by medications. It's this dually-eligible population that
21 has necessarily made the transition on January 1, 2006 from
22 receiving medications through a state-operated Medicaid
23 program to this new federal Medicare benefit.

24 As Dr. Kelman will reference, we are now moving
25 from the period of acute transition during the first three

1 months of the program and moving into a period of more what
2 you might call "ordinary time." This has been a monumental
3 task for the people who work at CMS to implement in a
4 relatively short period of time for literally millions of
5 Americans, yet time and time again those of us who are
6 external to CMS but observers of the process have witnessed
7 the successful resolution of a variety of issues of all
8 levels that have come up and could have impact on members
9 of the mental health and substance abuse community.

10 We're very grateful to CMS for the effort and
11 interest that they've had in the populations that we work
12 with, and at this time I'd like to introduce to you Dr.
13 Kelman. Dr. Kelman is currently the chief medical officer
14 of the Center for Medicare Beneficiaries within the Centers
15 for Medicaid and Medicare Services. Dr. Kelman was
16 educated at Harvard Medical School and is board certified
17 not only as an internal medicine physician, but also as a
18 geriatrician and pulmonologist.

19 Through the last six months, I have come to
20 know Dr. Kelman as both a gentleman and a scholar. He
21 contains in his head multiple minute details of the actual
22 law, regulations, and guidance on Medicare D. This
23 represents literally thousands of pages of government
24 documents that might be as tall as four to six feet tall if
25 you stacked them up end on end, and I've read many of them,

1 so I know they're that voluminous. Yet he is able to
2 graciously explain the same basic questions multiple times
3 to a wide variety of audiences. He has a good working
4 knowledge of mental health as well as substance abuse
5 issues and has been invaluable in helping to personally see
6 that a number of technical issues related to access to
7 medications that are of interest to our populations have
8 been resolved.

9 I present to you Dr. Jeffrey Kelman.

10 DR. KELMAN: Thank you, Dr. Everett, and thank
11 you, Mr. Curie.

12 I'd like to take this opportunity to thank
13 SAMHSA as a whole for the opportunity to speak here and for
14 all the help it has given us in both the planning and the
15 operationalizing of the Part D benefit, which hasn't been
16 an easy thing.

17 I'd like to particularly thank Dr. Everett, who
18 has been tireless in the effort to help us with this
19 benefit and taken a tremendous leadership position in
20 representing the interests of both the substance abuse
21 community and the mental health community.

22 Anita is actually minimizing her role, I think.

23 For the last four months, we have had weekly calls with
24 her. I've had them myself, and they've raised both policy
25 issues, plan-level issues, down to the individual

1 beneficiary issues requiring casework. As some of you
2 know, we've had 6,000 caseworkers working almost around the
3 clock since January 1st, and a tremendous number of their
4 activities and their actions have been triggered by cases
5 that Anita and SAMHSA have brought to my attention.

6 I'd like to, in the time available to me, touch
7 briefly on the entire Medicare Modernization Act because
8 there are issues there beyond Part D which are important
9 for the mental health community, and then focus on the Part
10 D drug benefit, which is really of the greatest interest to
11 us in the agency right now.

12 The MMA has a set of research projects,
13 demonstration projects, and Title 2, which is the Medicare
14 Advantage projects, as well as Title 1, which is the Part D
15 drug benefit.

16 To very briefly go over a few of the issues, a
17 few of the areas, the research project that I would like to
18 mention and remind people is the 723 data warehouse because
19 it has real potential for telling us things about health
20 care in this country which we have no other way of knowing.
21 This is a 5 percent, fully deidentified, fully encrypted,
22 linked database of the Medicare population using Part A
23 data, Part B data, Medicare Advantage data, Medicaid data,
24 OASIS data from home health, and NDS data from nursing
25 homes.

1 It will enable us for the first time to really
2 investigate the different effects of interventions and
3 outcomes for the population as they go between levels of
4 care and levels of service and age into Medicare, and the
5 question that also has been brought up as to really
6 identifying the outcomes and the cost of, say, outpatient
7 intensive psychotherapy. It's very hard to do up until
8 now, but we actually have a chance to get at it by
9 following groups of individuals three times, from home
10 care, hospitalization, the nursing home, the assisted
11 living, watching their intervention, their CPT codes,
12 looking at their diagnosis, their ICD-9 codes and DRGs, and
13 looking at their costs through summarizing aggregate
14 Medicare data. This can be done through the county level
15 and I think has a huge possibility, if not probability, of
16 helping us get some handle on cost-effective treatment and
17 quality of care.

18 Then there are demonstration projects. There
19 are a lot of demonstration projects under MMA. There are
20 group practice demonstration projects, there are integrated
21 data demonstration projects, and there are also the so-
22 called 721 demonstration projects. It used to be called
23 Product Care Improvement Project. Now it's the Medicare
24 Health Support Program.

25 This gets to the question of disease

1 management. Everybody talks about disease management and
2 we have programs that come in almost every month
3 guaranteeing improved quality and the cost.

4 A couple of weeks ago, I actually added up all
5 the cost savings that we would accrue if we actually used
6 all of these disease management projects, and if you
7 believe it, Medicare would turn into a revenue center for
8 the government, not a cost center, by the year 2010.

9 Be that as it may, there presumably are
10 projects that will be quality projects and at least be
11 cost-neutral or cost-benefit-positive, and this Medical
12 Health Support Program aims at getting at that. We have
13 taken bits from disease management groups, specifying
14 specific populations with specific diseases -- the most
15 common are diabetes, chronic lung disease, chronic heart
16 failure -- and populations in specific areas where disease
17 management companies work.

18 If we accept the bid, we create a pool of
19 volunteers. These are all volunteer beneficiaries,
20 volunteer enrollees. We randomize them to the disease
21 management program and standard care, and then we follow
22 them over time looking at the parameters first set by the
23 entity, first set by the disease management group, which
24 have to have quality parameters. Morbidity or mortality
25 issues first, of course, but also cost parameters.

1 One of the mantras that we've used for years
2 and we still believe is that quality care is cost-effective
3 care, and we have a real chance on proving this through the
4 721 project. There is no reason that mental health disease
5 management can't be used as well and we look forward to
6 programs and submissions from that group. With any lucky,
7 by the time the project has finished or has gotten through
8 a second or third year, we'll know which disease management
9 works, which ones are cost-effective, and what some best
10 practices are.

11 I'd like to touch for a moment on Title 2,
12 which is Medicare Advantage. It used to be called Medicare
13 for Choice, formerly Medicare HMO.

14 Everybody knows what HMOs are, but a lot of
15 people don't realize that this year we have a new kind of
16 Medicare HMO, a Special Needs Plan or SNP. These allow
17 entities that meet our requirements of quality, solvency,
18 and responsibility to submit and market to specific groups
19 of patients, such as dual eligibles, institutionalized
20 patients, or even the mean groups of patients. For
21 example, there's one HIV SNP that has been activated this
22 year.

23 It gets to the issue as to whether you can
24 align incentives in coordinated care to improve quality and
25 maintain cost. It always struck me as odd when I was in

1 the real world that if I had a patient in a nursing home
2 and did a bang-up job at keeping them out of the hospital
3 by providing intensive care in the nursing home, it was
4 extremely costly for the nursing home and the only one who
5 saved money was actually Medicare.

6 The Medicare Advantage Special Need Plans allow
7 extra services to be put in place for this population to
8 prevent hospitalization and improve both quality and cost
9 at the least restrictive level. It has tremendous
10 potential I think for the mental health population because
11 in that population the ability of true cognitive-behavioral
12 therapy intervention in the community probably has the
13 greatest quality and cost outcome of any of these groups
14 that we're talking about, and I think the Special Need
15 Plans in the next three to five years are going to be a
16 major impact on the way we practice medicine, and a major
17 part of that impact on high-cost, high level of disease
18 outcomes.

19 Now to get to Part D, which probably most
20 people have heard about because it's been in the papers
21 more than I personally would have wished in the last four
22 months.

23 As everybody knows or should know by now, it's
24 the biggest change in Medicare since 1965. It addresses a
25 gap that we've had in furnishing prescription drugs to

1 Medicare enrollees since 1965. It was done by a private
2 bidding system, effectuated by private plans that have bid
3 against the national benchmark to offer the benefit.

4 This was actually was very successful. Nobody
5 quite knew how it would work out. It's never been done
6 before, but initially the projection was for a \$37 premium.

7 At time of release, it was \$32, and at the present time
8 the average weighted premium is closer to \$25. This seems
9 directly due to successful acquisition costs of drugs and
10 operational costs, and will result in improved drug prices
11 for individuals because the acquisition cost of drugs that
12 the plans see are turned over to the beneficiary at the
13 counter.

14 This really has to be seen as three separate
15 benefits in a way. First of all, it's a catastrophic
16 reinsurance benefit where at \$3,600 out of pocket for all
17 beneficiaries their exposure to drug costs falls to 5
18 percent or lower. Everybody who has been in the health
19 field knows of some patient or groups of patients who have
20 been bankrupted or forced into Medicaid by drug costs in a
21 given year. The drug costs for very effective medications
22 in our society can run as high as \$100,000 a year. No one
23 should be bankrupted again under Part D and this benefit,
24 the catastrophic benefit, would really stand on its own.

25 There's also the standard benefit which

1 everybody gets who enrolls. There's a premium ranging from
2 lows of a couple of dollars to much higher premiums. There
3 is a \$250 standard deductible. There's a coverage spread
4 between \$250 and \$2,250 where the beneficiary sees a 25
5 percent cost share. There is a gap, the so-called donut
6 hole, through \$5,100 on average where the beneficiary pays
7 the full amount of the negotiated rate, and then it reaches
8 the catastrophic level. This is not a complete benefit,
9 but for most of our beneficiaries it's a huge relief of
10 burden from their current drug costs.

11 Now, there's a third benefit, which is a low-
12 income subsidy benefit which enables us to provide the drug
13 benefit to our most needy at a complete cost. This
14 includes both the full-benefit dual-eligible Medicaid --
15 there are about 6.1 million in that segment and they are
16 being transferred from Medicaid coverage to Medicare
17 coverage as of January 1st of this year -- but in addition,
18 there are another projected 8.1 million beneficiaries who
19 are between 100 and 150 percent of federal poverty. In
20 general, this group has no governmental coverage and the
21 vast majority have no private coverage. They couldn't
22 afford it.

23 Starting now, they get a complete benefit, a
24 minimal premium, no deductible, and minimal cost share,
25 most of them between \$2 and \$5 per prescription. No gap,

1 no donut hole, and the catastrophic benefit at \$2 and \$5.

2 It's a complete benefit, it never existed
3 before, and my friend the economist tells me that it
4 affects that population which has most elastic demand for
5 drugs. This is the group that actually don't take their
6 drugs because they don't have money. They split pills.
7 They substitute drugs for food or they run out of drugs at
8 the end of the month and don't refill the prescription.

9 We're expecting, and everyone's expecting, much
10 greater compliance with medication regimens for this group,
11 and in fact for any group that had no insurance last year
12 and has insurance this year, and as a result, if you
13 believe in drug therapy at all, we're hoping to see savings
14 in total medical care because of this increased compliance
15 with drugs, particularly in the mental health where the
16 population is at risk for compliance in the best of
17 circumstances. Relieving some of the financial woes should
18 increase compliance, increase drug usage, and reduce
19 unnecessary admissions, unnecessary decrease in status and
20 lost community independence.

21 The question comes up as to what are our
22 protections for beneficiaries? Well, we have a lot of
23 protection, particularly in formularies. What we did to
24 create formularies -- and this took a tremendous amount of
25 time last year and it's continuing to take time because new

1 formularies are coming for 2007 -- is we used USP, which is
2 a congressionally mandated independent body, to give us
3 guidelines.

4 They suggested classes and categories for ideal
5 formularies in which two drugs, or at least two drugs, had
6 to be present. They also gave us a series of formulary key
7 drug types, which they felt covered the entire gamut of
8 useful drugs. We've included all of those in the benefit.

9 We also include checks for commonly used drugs, best
10 practice drugs, and a very strong check on
11 antidiscrimination where we made certain that no individual
12 demographic group or disease group was discriminated
13 against under this benefit.

14 On top of that, we added six classes of special
15 concern in which we mandated that all or substantially all
16 drugs be included. These include chemotherapy,
17 immunosuppressants for transplants, and antiviral drugs for
18 AIDS, and most relevant, antipsychotics, antidepressants,
19 and anticonvulsants, which include the mood stabilizers.
20 Any patient entering Part D on one of these drugs in a
21 stabilized state would continue throughout the calendar
22 year. There basically were no exceptions.

23 We also put into place an entire structure of
24 access requirements where we insisted that the plan meet
25 retail TRICARE access, which is 90 percent of the

1 beneficiaries have to be within two miles of the city, 90
2 percent within five miles of the suburbs, and 70 percent
3 within 15 miles in rural settings. We achieved these
4 criteria in every state but Alaska, which, by the way, had
5 we used every formulary, every pharmacy, in the state,
6 which we did, would not have quite achieved it, but in
7 Alaska we got basically full penetration.

8 We also require that for institutions,
9 particularly long-term care institutions, that all the
10 plans be in a position to deliver drugs to every
11 institution in its region. We put a particular focus on
12 institutions, and that includes the IMDs as well as skilled
13 nursing facilities and ICFs and MRDDs.

14 In these institutions, we require delivery,
15 special performance and service criteria as determined by
16 the institution, including community standards of
17 packaging, and there is a special line in the law that
18 gives individuals who are full-benefit dual eligible but in
19 institutions special rights. They zero co-pay. All
20 individuals in institutions have the right to change plans
21 at any point in the benefit. That previously was a right
22 reserved to the full-benefit dual eligibles in the
23 community. And a special transition period for drugs.

24 We've included, by the way, for (inaudible)
25 institutions a special emergency-first fill criteria where

1 individuals at an institution have to be filled while in
2 the first seven to 14 days and get their prescription paid
3 for while the early stages of appeal and exception are
4 worked out.

5 The appeals and exception protection are also
6 very important. The Part D benefit, beyond formulary
7 maintenance, indicates that every single medically
8 necessary FDA-approved drug be available to the beneficiary
9 with the exception of certain excluded drugs. These are
10 excluded by statute, a 1927 D2 list, and they include
11 things such as certain prescription vitamins, weight gain
12 drugs, and barbiturates and benzodiazepines.

13 I'm happy to report that 49 state Medicaid
14 offices have seen fit to include and cover the
15 benzodiazepines and the barbiturates for beneficiaries that
16 cannot get them on Medicare D, but what that really means
17 is that no matter what is on the formulary, a beneficiary
18 has the right to file an exception to get a drug that he
19 needs.

20 There are two kinds of exceptions. There are
21 formulary exceptions for all formulary drugs and then a
22 unique exception process in the Part D benefit in that we
23 allow tiering exceptions and drug utilization management
24 exceptions.

25 A tiering exception refers to the fact that for

1 people who don't have an (inaudible) subsidy or enough of a
2 benefit for dual, they may have to pay different prices for
3 generic drugs, a preferred brand drug, or a non-preferred
4 brand drug, or a specialty tier drug, and we allow the
5 beneficiary to appeal that pricing if they wish and if it's
6 felt to be medically necessary. This is not found in any
7 commercial formulary I've ever seen.

8 We also allow exceptions and appeals of drug
9 utilization management techniques. These specifically
10 refer to things like step therapy, quality limit, or prior
11 authorization. We allow the beneficiary, if he's
12 unsatisfied with the prior authorization need or the step
13 therapy requirement and feels that it shouldn't apply to
14 him because of a unique circumstance, to apply for an
15 exception to that technique.

16 The exceptions and appeals have to meet very
17 stringent federal requirements of time. There an expedited
18 and a non-expedited appeal, and the expedited appeal can be
19 reached by request of a physician. In the expedited
20 appeal, the plan's coverage determination must be in 24
21 hours and redetermination within three days, at which point
22 it goes to an independent review entity, the so-called Part
23 D QIC, qualified independent contractor, which is outside
24 of the plan and makes an independent assessment of the
25 appeal.

1 In an expedited appeal, their answer has to
2 come within a total of seven days. At that point, if the
3 results are not positive in favor of the beneficiary, then
4 they have the right to appeal to an administrative law
5 judge and in fact, beyond that, to federal court.

6 These are extremely short timelines, we monitor
7 these closely, and we expect that everybody will get
8 medically necessary drugs in a timely fashion without
9 exception.

10 There's another interesting outcome of the Part
11 D benefit which some of us didn't expect, and that includes
12 me, and that has to do with the effect of having a unified
13 system of drug information. Every time a drug changes
14 hands in the Part D, 35 data elements are sent to CMS and
15 to the plan, and this took electronically systemwide an
16 extreme amount of effort because starting January 1st,
17 every pharmacy from Guam to the Virgin Islands is connected
18 electronically to the plan and to CMS through the so-called
19 truth facilitator, where the patient record is encrypted as
20 needed at point of sale. It means that a patient can go
21 anywhere in the country with a Part D card to a network
22 pharmacy and that pharmacy can determine his medication on
23 formulary, his exact price at that time of the benefit, and
24 the co-pay he sees.

25 Between 4 and 8 billion data elements are going

1 to come into CMS at the end of the year, or actually
2 throughout the year, which gives us a tremendous
3 opportunity to establish what could be called an early
4 version of a personal health record, an electronic health
5 record for drugs for our Medicare beneficiaries. We see it
6 already with certain of the coverage determinations that
7 we're getting in the Part D. There are two examples that I
8 can think of in the last three weeks that are sort of
9 typical of this story.

10 I got a note that a patient's digoxin was
11 turned down at point of sale, which is very unusual. It's
12 a standard drug, it's generic, it doesn't cost much. It
13 makes no sense.

14 When I followed up with the provider, it turned
15 out that the plan had turned it down because it was a 0.75
16 milligram dose, which is actually very high. It's not
17 unknown, but it's a high dose, which triggered an automatic
18 step edit. When I found the provider, it turned out he'd
19 written 0.25 milligrams. His handwriting is like mine, and
20 it was a transcription error.

21 This step edit probably saved that patient's
22 life. Not long afterward, I got a request to look into a
23 case where a patient's antipsychotic was actually stopped.
24 Now, this shouldn't have happened because, as we
25 mentioned, all stabilized patients have the right to

1 continue with their antipsychotic medication into the
2 calendar year.

3 In this case, it turned out that four different
4 providers were, unbeknownst to each other, writing for four
5 different antipsychotics. The patient, I believe, was on
6 Zyprexa, Seroquel, risperidone, and Abilify, and he was
7 being filled at different pharmacies. In fact, by the end,
8 he was being filled by his daughter's different pharmacies
9 because the patient was in no shape to get up and go out.

10 It turned out that the various providers were
11 unaware of each other and were using appropriate dosing,
12 appropriate therapy, but at dangerous levels because of the
13 communication gap. In this case, the communication gap was
14 bridged by the Part D record, and we're expecting
15 progressive improvements on this. It will be interesting
16 to see at the end of the year -- and we monitor this,
17 because we look at plan metrics for quality and performance
18 -- how much drug therapy is normalized and how many errors
19 are picked up over time.

20 I mean, everybody has read the Institute of
21 Medicine report which indicates that there are 20 or so
22 percent drug errors in the community, possibly as high as
23 40 percent potential drug errors in the institution. It
24 would be nice, at least for our Medicare beneficiaries, if
25 we improved the error rate just by the fact that we've got

1 better communication tools to follow drug therapy in this
2 country.

3 As we go forward, we're going to hope to refine
4 the delivery of the benefit, streamline the appeals and
5 exceptions to the benefit, and we've just posted a new
6 standardized appeals form which we worked on with the Part
7 D plan and the AMA work group, and SAMHSA has been a major
8 partner in that, and look forward to improving best
9 practices in drug administration throughout the country.

10 Thank you for the opportunity to speak. We
11 hope to continue working with SAMHSA for the foreseeable
12 future.

13 MS. KADE: Thank you, Dr. Kelman.

14 This is Daryl Kade again. At this point, I'd
15 like to acknowledge the presence of our centers. Dr.
16 Clark, the center director for CSAT, Rose Kittrell, acting
17 deputy center director for CSAP, and Ted Searle, deputy
18 director for CMHS.

19 I also want to mention that Barbara Huff has
20 joined the call, and that Thomas Lewis is ill and will not
21 be joining the call.

22 I'd like to remind the members of the rules of
23 the discussion. The members will be called in alphabetical
24 order. Each member will have three minutes to ask one
25 question or provide one comment. A timer, and Toian is the

1 keeper of the timer, will be set to remind you of your
2 allotted time. When it rings, you will have 30 seconds to
3 complete your question or comment. Staff presenters will
4 have three minutes to respond. We have allowed 60 minutes
5 for the first round of discussion. If time permits, we
6 will begin a second round of questions and answers.

7 So I'm going to start with Lieutenant Governor
8 James "Duke" Aiona.

9 MR. AIONA: Thank you. Actually, somebody can
10 take up my time, because I have no comments or questions at
11 this point. Or can I reserve it?

12 MS. KADE: When we start the second round.
13 How's that sound?

14 MR. AIONA: Very good. Thank you.

15 MS. KADE: Ms. Dieter?

16 MS. DIETER: Yes, I'm just very impressed by
17 the breadth and details for individual situations to be
18 addressed in the whole process. It's fascinating and very
19 interesting.

20 Thank you.

21 MS. KADE: Thank you very much.

22 Dr. Gary?

23 DR. GARY: Thanks out there. There's evidence
24 of a lot of thought and a lot of hard work that has gone
25 into conceptualizing and implementing this plan.

1 My first comment is I'm most appreciative of
2 the statement that we heard today, and I'm wondering if
3 they could be available to me and perhaps other Council
4 members through the Internet or through an email. I think
5 the information is exceptionally important and certainly
6 would help me with my thinking in future times of
7 deliberation.

8 That's my comment. My question is that I would
9 like to have some more discussion about this wonderful
10 database that I'm hearing and have the opportunity to
11 dialogue about other uses for this database that's being
12 developed. In particular, the database and how it could be
13 directly tied to issues of access and issues of coherence
14 in terms of treatment modalities, follow-through, and
15 practitioner behaviors with regard to prescriptive
16 authority and the prescribing of certain types of
17 medications for certain disease management purposes, but
18 also for certain populations.

19 I think we are on the brink of getting a whole
20 different level of understanding of what might create and
21 maintain health disparities, especially among those
22 individuals who have complex illnesses, such as mental
23 disorders, substance abuse, as well as physical health
24 disorders, heart disease, diabetes, cancer, et cetera.

25 So I'd like to have some more deliberation

1 about that, and to figure out how we could maximize the use
2 of this wonderful database that I'm hearing.

3 From a different level, I did not hear much
4 discussion about mental retardation because we do also know
5 that there are a lot of dual overlap with mental
6 retardation, behavioral-related kinds of expressions, that
7 are typically treated with psychotropic medication among
8 that population.

9 The final one is on my end, before this
10 conference I had conversations with people who are in the
11 throes of trying to decide what plan they would select, and
12 a lot of the individuals I've talked with are people who
13 are related to churches, et cetera, and I'd just like to
14 advance the thought about preparation of statements that
15 could be placed in church bulletins that would be very
16 clear, very pristine, very brief, but would help to provide
17 people with additional kinds of information that they would
18 feel that they're directly linked to the source of perfect,
19 good information and could benefit from the kind of
20 expertise that's generated from the top down, if you will.

21 Thank you so very much for this hard work that
22 you've done.

23 MS. KADE: Thank you very much.

24 Dr. Kelman?

25 DR. KELMAN: Well, I appreciate the input. The

1 database, and all the databases, are very much an active
2 project right now because we hope to use them not only for
3 research techniques, but for quality measurement and for
4 so-called pay for performance or value-based purchasing if
5 they're going to give us, hopefully, a real insight into
6 the population as a whole and segmenting the population any
7 way that's been useful.

8 In terms of summary of the benefit, we would
9 tremendously appreciate any opportunity to deliver
10 information to groups that may not have heard about the
11 benefit or don't know the best way of approaching it. We'd
12 particularly like help in getting people to sign up for the
13 low-income subsidy. That's the group between 100 and 150
14 percent of federal poverty, and that application has to be
15 made with an affirmative action. It's not like the full-
16 benefit duals who are automatically enrolled. If someone
17 doesn't apply for the low-income subsidy, they won't get it
18 until they do apply.

19 We did extend the ability for somebody who's
20 newly approved in low-income subsidy to join a plan after
21 the cutoff date of May 15th, but they need to be helped to
22 apply. It can be done through the Social Security Office.
23 It can be done online. We're looking for venues to help
24 people apply, sign up, and then get the benefit. Once they
25 apply and get it, it will pretty much, unless they come

1 into an unusual windfall, last them through the point of
2 the program.

3 I thank you for the invite.

4 DR. GARY: Thank you.

5 MS. KADE: Thank you.

6 Ms. Holder?

7 MS. HOLDER: Hi. This is Diane Holder. I am
8 first of all wanting to say also that I think that this is
9 really a monumental point in history where we're going to
10 begin for the first time to be able to address the needs
11 that many people have had for medication that they've been
12 unable to access appropriately and that we really do want
13 to begin to look at the kinds of things that we can bring
14 together from a program perspective.

15 I think the Special Need Programs that are
16 being implemented around the country are going to be very
17 important programs for us to keep our eye on. We know that
18 very often the most vulnerable people are the ones that
19 slip through the cracks, and my hope is that, given the
20 structure that's being put around these type of programs
21 from the federal government, and also the kind of oversight
22 that's being required, will help us to ensure that these
23 kinds of programs do optimal things for the people that
24 we've been the most concerned about over the years.

25 One of the issues that does concern us related

1 to the whole Part D and the Medicaid program is how
2 difficult this often for older people to understand and the
3 complexities of choices that are available to them, and if
4 there's anything that we can do at a federal or state level
5 that could help make this less confusing people -- and I
6 know everybody's been doing their absolute best to try to
7 make this easier, but if there are ways that we can think
8 of from the SAMHSA perspective to be helpful, I think that
9 would be very important.

10 That's really all that I wanted to say. Thank
11 you.

12 MS. KADE: Thank you.

13 Ms. Huff?

14 MS. HUFF: Hello. I'm sorry I was late getting
15 on. I apologize for that. The different time zone gets to
16 me every now and then. So first of all, let me apologize.
17 I was about 10 minutes late.

18 I also want to reiterate the fact that this has
19 been so very helpful and I'm so glad as a Council we
20 decided to postpone the information that was due to be
21 delivered at the last Council meeting so we would have more
22 time. It has been very helpful and very useful
23 information.

24 I would also like to reiterate the fact that
25 for all of the older adults that I know, they are

1 struggling with the complexity of things. So I would agree
2 that if there's any way that it could be streamlined for
3 most older adults, who struggle anyway just in their mental
4 capacity as they get older and things are harder to
5 understand, I think this has really taken a lot of people
6 kind of over the top, so to speak.

7 So I would encourage us to also look at those
8 opportunities, but this has been useful, helpful
9 information, and I wanted to say thank you very much.

10 MS. KADE: Thank you.

11 Dr. Kirk?

12 DR. KIRK: Good afternoon. Thank you.

13 I have a specific question as a state facility.
14 There are a number of patients who are eligible for
15 Medicare that are also eligible for Medicaid, but their
16 Medicaid coverage is suppressed because of the length of
17 time that they're in one of our facilities, and I have a
18 difficult time identifying dual eligibles and this impacts
19 on co-payments and premiums.

20 Any suggestions about how we could coordinate
21 with CMS to get these individuals recognized as dual
22 eligible and where they're not recognized as dual eligible,
23 are they only able to change an enrollment during the
24 annual open enrollment period?

25 DR. KELMAN: A very good question and it has

1 come up, and it's important because it may not be obvious
2 from the materials we've sent out. We base our dual
3 eligible decision on the state lists. If the state
4 recognizes them as dual eligible for the terms of Part D,
5 we will accept them as such, and if the state sends them on
6 their monthly form, we will enroll them as dual eligibles
7 and give them the zero institutional co-pay.

8 If a state cannot do that, what we have been
9 recommending is an immediate application for the low-income
10 subsidy. It can be done online through ssa.gov. I'm
11 assuming that the dual eligibles in institutions actually
12 have no assets and would fit in the lowest level low-income
13 subsidy.

14 When the application is made, Social Security
15 claims a four- to six-week turnaround, or less online, with
16 the coverage going back to the beginning of the month in
17 which the application was made. That would cover basically
18 the complete benefit except for the co-pay in the
19 institution. When Medicaid is granted, even if it's
20 retroactive six months later, it will go back to the first
21 of the month in which the application was made and deemed
22 eligible, and all the co-pays will be reconciled back to
23 zero.

24 DR. KIRK: Can I make a comment?

25 DR. KELMAN: Please.

1 DR. KIRK: Actually, we're trying to avoid
2 doing that because of the paperwork on over 300-plus
3 people, the application process. Any suggestions you can
4 give us as to how we can do it in a reasonably smooth way,
5 we'd greatly appreciate it.

6 DR. KELMAN: Thank you. We will try. I take
7 it your state hasn't been willing to enroll these people
8 and count them as Medicaid? The easiest way is if the
9 state sends us in their monthly files the names of these
10 individuals -- in fact, all the institutional individuals
11 -- who qualify as full-benefit dual eligibles. Then it
12 becomes automatic.

13 DR. KIRK: That's the issue. Our Medicaid
14 agents don't have these people in their data files and so
15 they never show up as dual eligible.

16 DR. KELMAN: That's basically where we get the
17 information as well. As you know, Medicaid status is a
18 state determination, and so if it doesn't come from the
19 state, then the only means we have to reduce the premium is
20 through the low-income subsidy application.

21 DR. KIRK: All right. Thank you.

22 MS. KADE: Thank you.

23 Ms. Racicot?

24 MS. RACICOT: I just have a quick comment,
25 mainly a thank you to everyone who has worked so hard to

1 try and bring this benefit about to our most needy
2 citizens. It sounds extremely complicated and I know there
3 have been a lot of hours and good thought gone into it, and
4 I just want to thank everyone, and thank you for the
5 opportunity to hear it today.

6 MS. KADE: Thank you.

7 Mr. Stark?

8 MR. STARK: This is Ken Stark. I have no
9 questions related to Part D. I do have some other
10 questions related to CMS, maybe later in Round 2.

11 But I would like to make a comment briefly, and
12 that is on the database. As a state who has done a lot of
13 evaluation using administrative databases, including the
14 Medicaid database linked with alcohol and drug treatment
15 records and criminal justice records and employment
16 records, I think you have a really good opportunity to
17 start doing some analyses with that database in tracking
18 some of the outcomes, and I, for one, am certainly excited
19 that you all are looking at that.

20 MS. KADE: Very good. Thank you.

21 Ms. Sullivan?

22 MS. SULLIVAN: Dr. Everett, thank you so much
23 from all of us here on the Council. We really appreciate
24 your effort at SAMHSA.

25 Dr. Kelman, what a very, very interesting and

1 comprehensive presentation. I appreciate it so very much.

2 My only question is right before you talked
3 about the exceptions and appeals, my question is about when
4 certain drugs, specifically in the mental illness field,
5 show a certain efficacy and are what could be perceived as
6 relatively new, within one or two years, some of the HMOs
7 and providers are very slow on the uptake to put them on
8 their drugs that are covered, on their prescribed list.

9 Is Medicare sending out any lists encouraging
10 some of the providers to put these on the list. You said
11 you were going through this exceptions and appeals process
12 and cut that back?

13 DR. KELMAN: Well, we just sent out our
14 guidance on the 2007 formularies and it was very similar to
15 2006, in which we continue to require all the
16 antipsychotics or substantially all of them, all the
17 antidepressants, and all the antiseizure drugs, which
18 include the mood stabilizers. So new drugs that come on
19 the market before bid submission will automatically have to
20 devolve on to the formulary.

21 MS. SULLIVAN: Thank you.

22 MS. KADE: Thank you.

23 We have finished our first round and we're
24 ready for the second round. Lieutenant Governor Aiona?

25 MR. AIONA: Again, I join in with the comments

1 of appreciation and thanks to our presenters today, Dr.
2 Kelman and Dr. Everett.

3 I kind of got a little lost on the access
4 requirements that you discussed. Could you go over that
5 real briefly again, Dr. Kelman?

6 DR. KELMAN: Sure, Governor. Which access?
7 The TRICARE access?

8 MR. AIONA: Yes.

9 DR. KELMAN: We have different kinds of access.
10 That's the main one.

11 First of all, most of the plans do offer mail
12 order, which is a separate issue because that's a standard
13 and not an access.

14 We have community access and institutional
15 access. The institutional access obviously is focused on
16 the 15,800 skilled nursing facilities.

17 In the community access, we use the so-called
18 TRICARE standard, where every plan treated as an individual
19 plan has to have for its beneficiaries on its roll enough
20 pharmacies in urban areas such that 90 percent of the
21 beneficiaries are within two miles of a pharmacy; in
22 suburban areas, such that 90 percent of beneficiaries are
23 within five miles of a pharmacy; and in rural areas, that
24 70 percent of the beneficiaries are within 15 miles of a
25 pharmacy, taken as a state. It's not enough to amortize it

1 over a four-state or a three-state region. We have 34
2 regions. So taken as a state.

3 In the institutions, because it was obvious
4 that TRICARE standards don't apply, we could actually have
5 put a pharmacy outside every nursing home and it wouldn't
6 do any good because these vulnerable residents can't go out
7 and get drugs. We require that the plans actually are in a
8 position to deliver to the institutions in their region in
9 which they have even one resident.

10 MR. AIONA: Thank you.

11 One question. What's the definition of a rural
12 area?

13 DR. KELMAN: We follow the TRICARE definition,
14 the TRICARE geo access, the Department of Defense.

15 MR. AIONA: Thank you.

16 DR. KELMAN: Thank you.

17 MS. KADE: Ms. Dieter?

18 MS. DIETER: No questions. Again, thank you so
19 much, Dr. Kelman and Dr. Everett. I'm just fascinated as
20 to how this database may be able to be used and looking
21 forward to that. Thank you.

22 MS. KADE: Thank you.

23 Dr. Gary?

24 DR. GARY: Faye Gary. I thank you for the
25 opportunity to ask another question.

1 I would like some more discussion, please,
2 about the mental health disease management demonstration
3 project. Specifically, what populations do they focus on?
4 For example, children, adults, the elderly, or certain
5 disease entities, et cetera? And indeed, will these mental
6 health disease management programs be tied to the same
7 database that we've been talking about and will it also be
8 tied to issues of access, for monitoring, and for being
9 able to determine best practices, evidence-based practice,
10 et cetera?

11 DR. KELMAN: In terms of the Medicare Health
12 Support Program, we are accepting proposals from entities
13 for any Medicare group of enrollees, and so it's any
14 disease as defined. I don't know that we've actually got
15 any from the mental health community yet. We certainly
16 have them for diabetes, congestive heart failure, asthma,
17 and COPD.

18 Once the proposal is received, the entity has
19 to define both the population it's interested in and the
20 criteria it sees as important for disease management.
21 We're assuming that quality -- in fact, we're requiring
22 that quality improvement be the first part of the proposal
23 with specific metrics on improvement. In diabetes, for
24 example, it would include improvement in hemoglobin A1C,
25 reduction in kidney failure, reduction in blindness, that

1 kind of clinical improvement.

2 In addition, they have to define what
3 intervention they're using and how they're going to measure
4 the quality outcome as well as the cost outcome. We'd be
5 more than happy to see this kind of proposal in mental
6 health as well.

7 DR. GARY: Thank you.

8 MS. KADE: Thank you.

9 Ms. Holder?

10 (No response.)

11 MS. KADE: Ms. Huff?

12 MS. HUFF: I would like to know if you could
13 describe that definition of rural. It came up earlier by
14 the Lieutenant Governor when he asked about the definition
15 of rural and how you define it.

16 DR. KELMAN: I actually have to admit I can't
17 describe the TRICARE Department of Defense approach to
18 rural. It is in actually the Department of Defense TRICARE
19 Act, and we use the Department of Defense maps to define
20 rural for our interpretation. I wish I could go beyond
21 that, but I'm sorry that I can't.

22 MS. HUFF: No, that's all right. That would be
23 hard to describe a map probably at this point. Thank you.

24 MS. KADE: Thank you.

25 Dr. Kirk?

1 DR. KIRK: Yes, thank you. I've got another
2 specific question operational.

3 For those who individuals who are in inpatient
4 psychiatric facilities and they're not recognized as dual
5 eligible, unless they're seen as Medicare only, are they
6 only able to change enrollment during the annual open
7 enrollment period or, like the duals, can they change on a
8 monthly basis?

9 DR. KELMAN: If they're an institution as we
10 define it, which includes the IMDs, ICFs, and MRDDs as well
11 as skilled nursing facilities, they have a separate open
12 enrollment period where they can change on a monthly basis
13 as well, independent of whether or not they're dual
14 eligible. Someone who has assets in an institution has the
15 same rights to change also.

16 DR. KIRK: Outstanding. Thank you.

17 MS. KADE: Thank you.

18 Ms. Racicot?

19 MS. RACICOT: I have no comment at this time.

20 MS. KADE: Mr. Stark?

21 MR. STARK: I want to follow up on your
22 comments that you just made back to Tom Kirk. I'm not a
23 Medicare/Medicaid expert by any means, but if somebody is
24 in an IMD, do I understand you to say that they wouldn't
25 necessarily lose their benefit?

1 DR. KELMAN: Absolutely not. They continue
2 their benefit.

3 MR. STARK: That's a good thing.

4 DR. KELMAN: I think so, too. We went to a lot
5 of trouble to make sure the IMD and the ICF and MRDDs were
6 included. We spent a lot of time and are very appreciative
7 of the work that the National Association of State Mental
8 Health Program Directors and National Association of State
9 Directors of Developmental Disability Services did and who
10 have been working with us on these issues as well.

11 MR. STARK: Thank you.

12 MS. KADE: Thank you.

13 Ms. Sullivan?

14 MS. SULLIVAN: Dr. Kelman, earlier when you
15 were talking about disease management programs, did you
16 actually -- we're on a conference call, but I think I heard
17 this correctly -- did you say that by the year 2010 that
18 Medicare would actually be a revenue center and not a cost
19 center?

20 DR. KELMAN: That was a joke.

21 MS. SULLIVAN: Oh. Thank you.

22 MS. KADE: Thank you.

23 We're ready for the third round. I'll try and
24 go through this quickly to see who would like to speak, and
25 if not, then we'll proceed to public comments.

1 Lieutenant Governor Aiona?

2 MR. AIONA: I have no comments. Thank you very
3 much.

4 MS. KADE: Ms. Dieter?

5 MS. DIETER: No comment. Thank you.

6 MS. KADE: Dr. Gary?

7 DR. GARY: I'll pass.

8 MS. KADE: Ms. Holder?

9 MS. HOLDER: No comment.

10 MS. KADE: Ms. Huff?

11 (No response.)

12 MS. KADE: Dr. Kirk?

13 DR. KIRK: I'll pass.

14 MS. KADE: Ms. Racicot?

15 (No response.)

16 MS. KADE: Mr. Stark?

17 (No response.)

18 MS. KADE: Ms. Sullivan?

19 MS. SULLIVAN: No comment. Thanks.

20 MS. KADE: I think at this point the round of
21 Q&As is over and we'll be ready for public comment.

22 Toian, you want to inform the operator?

23 Let me go over the rules of engagement for
24 public comments and then the operator can open it up.

25 It's my understanding that we just have one

1 public commenter on the line, and we have received a
2 request to comment from how many participants?

3 MS. VAUGHN: We have 39 members of the public
4 on the line and at this point in time, we only have one
5 individual that has registered who has indicated that he
6 would like to make a comment.

7 Now, the public had the opportunity to send
8 comments during the meeting and we did not receive any
9 comments on email, and I need to remind the public that
10 only if we had received comments, and you still could have
11 an opportunity to send comments in electronically, you have
12 to be on the call in order to have your comments read or
13 made a part of the record.

14 So we will now ask the operator to open the
15 line for the first commenter, and we ask the caller to
16 state your name and your organization. So we will first
17 start with the commenter on the line, and then we do have
18 individuals from the public here in Rockville. We'll start
19 first with the caller on the phone, and then we'll go to
20 the audience here in Rockville, and then we'll go back to
21 see if anyone on the call would like to make a comment.

22 MS. KADE: Very good. So the first public
23 commenter on the line, please?

24 THE OPERATOR: Thank you. If you would like to
25 ask a question, please press star 1. You will be prompted

1 to record your name. To withdraw the question, press star
2 2.

3 The first question is from Malcolm Spicer.

4 MR. SPICER: Yes, hello. This is Malcolm
5 Spicer, Substance Abuse Funding Week Newsletter.

6 Dr. Everett, in your opening remarks, you cited
7 some statistics regarding percentages of persons who are
8 dual eligible and of those who would have mental illness
9 and other data. Unfortunately, my call was not clear at
10 that point, and I didn't get the data you were referring
11 to. I couldn't understand what you were saying as far as
12 the data.

13 MS. KADE: What we can do, Mr. Spicer, is to
14 provide you with a copy of the transcript when it's
15 available.

16 MR. SPICER: Well, I kind of need that today.

17 MS. KADE: Thank you for your comment.

18 MR. SPICER: As in --

19 MS. KADE: Yes?

20 MR. SPICER: As in right now. I mean, the
21 other part of the call has been clear, but for some reason
22 her call was breaking up.

23 MS. KADE: What we'll do, if you give the
24 operator or me your number, we can get back to you later
25 on.

1 MR. SPICER: Very well.

2 MS. KADE: And we will send you her comments
3 even before the transcript is available.

4 MR. SPICER: That's very good. Thank you.

5 MS. KADE: You're welcome.

6 Can I have in the audience anyone who would
7 like to make a public comment?

8 (No response.)

9 MS. KADE: No one has taken the stand.
10 Is there another public commenter on the call?

11 THE OPERATOR: At this time, there are no
12 further questions.

13 MS. KADE: Very good. Then at this point, I
14 want to thank Dr. Kelman, the members, and the public for
15 participating.

16 We will be sharing Mr. Curie's comments and Dr.
17 Everett's comments, and Dr. Kelman, if there's something
18 that you have that you would like to share with the
19 members, please let us know and we will share that as well.

20 I wanted to announce the next Council meeting
21 is scheduled for June 28th and 29th. One is an
22 orientation, the other is the Council meeting per se.

23 I'm going to hand the microphone back to Toian
24 for some final administrative issues.

25 MS. VAUGHN: I actually have only one item, and

1 I'm asking the members who have not returned their
2 certification for personal services form to please do so
3 immediately following the meeting. I ask that you fax it
4 to me so that you can get paid.

5 Thank you, and have a very good evening.

6 MS. KADE: Thank you.

7 MS. VAUGHN: Thank you, Verizon. That ends the
8 call.

9 (Whereupon, at 3:25 p.m., the meeting was
10 adjourned.)

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