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Evaluation of the Medicare Prescription Drug Card and Transitional Assistance Program: Stakeholder Analysis

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Phase II
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Executive Summary

Introduction and Methods

There are notable similarities between the Medicare drug card program and the Part D drug benefit currently being launched. Both programs 1) invite the private sector to deliver a public benefit and seek to encourage competition among plans, 2) involve choice on the part of beneficiaries in terms of whether to enroll and, if so, which drug card/plan to choose, and 3) engage similar organizations (health plans, insurers, pharmacy benefits managers, pharmacies, manufacturers, organizations serving beneficiaries, and the States).

The purpose of the project entitled "Evaluation of the Medicare Prescription Drug Card and Transitional Assistance Program: Stakeholder Analysis" is to document and analyze the experiences and perceptions of four stakeholder groups (card sponsors, community pharmacy sector, manufacturers, and States). All are key players in both the drug card program and the Part D drug benefit. This Evaluation represents an opportunity to extract lessons from the drug card program that can be productively applied to various Medicare initiatives, including Part D.

This report is the second of two closely related reports. The Phase I report offered a broad overview of stakeholders' early perspectives on the drug card program, with a primary source of 137 interviews with various stakeholders including card sponsors, the community pharmacy sector, manufacturers, and organizations serving beneficiaries; most Phase I data were collected between November 2004 and February 2005. In Phase II, where data were collected between August 2005 and November 2005, we sought to document changes in stakeholders' perspectives on the program and what they believed they had learned from participating; we also added some other new topics.

This report draws on the following sources:

- Repeat individual in-depth interviews with 92 individuals interviewed in Phase I
- Individual in-depth interviews with 14 respondents from State Pharmacy Assistance Programs (SPAPs)
- Four community case studies
- Four focus groups with community pharmacists
- Secondary data on card sponsors
- Six major newspapers and two senior publications (free monthly newspapers aimed specifically at seniors) in the case study communities

While the project sought to emphasize *changes* in stakeholders' perspectives between the times of the Phases I and Phase II data collection, many respondents answered with general observations and repeated themes from Phase I. Respondents thought of the program as a whole and not two separate phases. In presenting our findings, we describe repeat themes briefly and new or changed themes in more detail.

Interview and Focus Group Findings

Changes in Approach to Drug Card During 2005

Universally, all groups of respondents reported that **they had not changed their approach to the drug card program during 2005.** Some beneficiary organizations had scaled back their outreach in response to limited beneficiary interest and the declining value of the remaining transitional assistance credit. Many respondents reported that their focus had shifted to Part D; some respondents relayed the perception that CMS' focus had shifted as well.

Overall Experience and Impacts

When asked to reflect on their overall experience with the drug card program and its effects on their organizations, many respondents said that the program had required significant effort. Organizations serving beneficiaries (State Health Insurance Plans (SHIPs), information intermediaries, and community-level respondents) all commented that it had been time-consuming and expensive to educate beneficiaries about the program and to assist them with the decision and enrollment processes; some stated that their funding and staff resources had not been adequate.

For three groups of private sector stakeholders (sponsors, pharmacies, and manufacturers), the financial impacts of the drug card program were minimal or negative. More than half of the card sponsors reported, unprompted, that they had not made money on the program. The majority of stakeholders agreed that the drug card program offered a learning experience for Part D and provided insights into administering a drug benefit, working with CMS, and communicating with beneficiaries.

Experience with CMS

As had been the case in Phase I, stakeholders painted a mixed picture of their experience working with CMS. On the one hand, there was a consensus that CMS staff members were hard-working, dedicated, and wanted to help. At the same time, many respondents described CMS staff as over-stretched and lacking the experience, expertise, and time necessary to effectively carry out their responsibilities.

Much more than in the first round of interviews, many private sector stakeholders reported that CMS treated them like *partners*. Sponsors, manufacturers, and pharmacy executives all commented that CMS had become more collaborative over the life of the program. Stakeholders tended to agree that CMS was effectively applying lessons learned in the course of the drug card program to the launch of Part D.

Some respondents reported only limited contact with CMS. These included several pharmacy executives, the majority of pharmacists, and some community-level respondents, notably at one site.

Role of Community Pharmacist in Helping Beneficiaries with Drug Benefits and Costs

Pharmacists seemed conflicted about their role in assisting beneficiaries with issues related to drug benefits and costs. On the one hand, they said that they would prefer to focus on clinical and drug therapy issues and not drug benefits issues. At the same time, many accepted these additional responsibilities as part of their job and even found it rewarding to help their customers in this way. It was important to pharmacists that beneficiaries view them as knowledgeable and trustworthy advisors; they disliked not knowing the answers to customers' questions and wanted to be better informed about Medicare drug benefits. Some respondents from this sector also disliked not being allowed to offer beneficiaries advice about choosing a Part D plan.

Experience Reaching Target Population and Experience with Beneficiary Choice
Echoing a theme from Phase I, virtually all stakeholders agreed that it was hard to reach Medicare beneficiaries, especially low-income beneficiaries, on the subject of drug benefits. In Phase II, stakeholders agreed on the following best practices for reaching the target population:

- Use a sustained, multi-media approach.
- Prepare for one-on-one conversations.
- Find community partners and work in community settings.
- Create community-level coalitions. A strong coalition leader (or other intermediary) can help bridge the gap between CMS and community-level partners.
- Make messages short, simple, clear, consistent, and customer-oriented.

In response to questions about helping beneficiaries with the choice among competing cards, respondents at beneficiary organizations reiterated a theme from Phase I: beneficiaries needed support to manage the large number of choices and to understand which drug card was the best fit for their personal circumstances. They observed that the process of helping beneficiaries was extremely time-consuming and that, in the majority of cases, it required personalized, one-on-one attention[1].

Experience Reaching Providers and Beneficiary Organizations
State Pharmacy Assistance Programs, beneficiary organizations, and professional organizations all sought to educate health care providers, such as physicians and pharmacists, about the Medicare drug card program; they also sought to educate staff at other organizations that had relationships with Medicare beneficiaries. These respondents all used existing partnerships to disseminate drug card program information as well as a variety of other methods: publishing newspaper and newsletter articles, providing train-the-trainer presentations to beneficiary organization and State agencies, and conducting trainings for other organizations that have regular contact with beneficiaries. Some respondents conducted training and presentations to educate and improve the knowledge of pharmacists and other groups that have direct relationships with pharmacists. Professional associations were central repositories of drug card information for many respondents and other organizations.

Experience with State/Sponsor and State/Federal Partnerships
Several of the sponsors and about half of the SPAPs interviewed had been involved in partnerships in which SPAP members were automatically enrolled into a preferred drug card, always with an option to opt out. In general, these respondents were pleased with these partnerships. In addition, several information intermediaries observed that auto-enrollment had worked well. [2]

One case-study community had met its goals for program enrollment via a three-way partnership between the State, a sponsor, and the Federal program. This community had used auto-enrollment and had fully integrated the Medicare drug card program (including the $600 credit) with the SPAP to

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[1] While the stakeholders interviewed for this report believed that beneficiaries were overwhelmed by the large number of choices, Abt's evaluation of the Medicare drug card's beneficiary impacts found that beneficiaries rarely considered more than one card and the majority had not sought help in their decisions.

[2] Consistent with this finding, Abt's evaluation of the Medicare drug card's beneficiary impacts found that in states with auto-enrollment there was a relative increase in participation in the drug card program and in transitional assistance.

provide a more valuable benefit. An active coalition, with State officials as engaged and visible partners, had then mounted a statewide campaign to publicize the enhanced benefit.

Information Needs and Sources

All stakeholders turned to CMS for at least some program information, although, as noted above, many community pharmacists reported minimal contact with CMS. Pharmacy executives, community pharmacists, and manufacturers also received information on individual drug cards from the card sponsors. When asked about gaps in the information available, many stakeholders suggested that CMS had covered the right topics but the information had been late, inconsistent, overly lengthy, and/or tough to navigate. Several stakeholders also noted a desire for information about the actual levels of enrollment into the drug card program.

To meet their needs for informational materials to share with beneficiaries, pharmacists and other organizations serving beneficiaries expressed a desire for clear, concise, accessible information about the drug card program and about the drug cards being offered, ideally in a format that facilitated inter-card comparisons.[3] In addition, respondents at beneficiary organizations called for instructional information that would help beneficiaries and counselors through the process of making choices and using the available Internet tools. Generally speaking, stakeholders' needs for information about Part D mirrored their needs for drug card information.

Findings from the Analyses of Secondary Data

Analysis of Secondary Data on Drug Card Sponsors

As a complement to the sponsor interviews and as a continuation of work in the Phase I report, we analyzed CMS data concerning the numbers of drug cards and the enrollment into those cards. This data show that the number of drug cards were relatively stable between July 2004 and July 2005. There were 73 general cards at both points; there were 82 exclusive cards in 2004 and 93 a year later.

Between July 2004 and July 2005, overall enrollment in Medicare-approved drug cards increased by 69 percent, from 3.85 million beneficiaries (3.85M) in 2004 to 6.5M in 2005. Over that time period, general card enrollment increased by 177 percent, from 1.36M to 3.77M, and exclusive card enrollment increased by 10 percent, from 2.49M to 2.73M.

Analysis of Newspaper Coverage in Case Study Communities

As part of the case studies, we analyzed coverage of the drug card program in six major newspapers and two senior publications in the four case study communities published between December 2003 and September 2005. The majority of articles published in these newspapers provided basic information on the Medicare drug card; many articles offered contact information for individuals seeking additional information. Articles that discussed the Medicare website and call center generally did so in a negative manner. Many articles emphasized the drug card program being confusing and overwhelming to beneficiaries. Newspaper coverage of the drug card program was concentrated in the periods after the passage of the Medicare Modernization Act and during the initial enrollment period of the drug card program. In general, articles in senior publications contained more detail than articles in major newspaper; often, they included a full description of the drug card's benefits and application procedures.

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[3] Although some respondents were not aware of these resources, CMS had created a number of one-page fact sheets, check-lists, and other brief summaries of key program features and published them on its website.

Discussion

For stakeholders, the direct impacts of the program, while real, were short-lived. The main legacy of the program was that it clearly offered stakeholders a learning experience that was relevant to Part D and possibly to other aspects of Medicare.

The drug card program established and strengthened networks and relationships among the stakeholders who would later provide the Part D drug benefit. It further engaged the health care community in the challenges associated with beneficiary outreach and choice among competing benefits. As a result of their drug card experiences, many sponsors believed that they had gained valuable expertise in the areas of administering a drug benefit, communicating with beneficiaries, and working with CMS. In the course of the program, the health care community developed some best practices for reaching beneficiaries. Many members of the health care community also cemented expectations, both positive and negative, for Part D.

While this legacy is important, it should also be considered in light of several points. First, the drug card program was a completely new program. Over time, some of the challenges that stakeholders emphasized may dissipate as beneficiaries and the wider community gain experience with Medicare drug benefits and associated concepts. Second, while some knowledge and experience gained in the course of the drug card program will transfer to Part D, the two programs substantially differ in terms of their details, the financial stakes involved, and the fact that Part D is permanent while the drug card was a two-year program. Given these differences, it is reasonable to expect that all parties will invest more resources in overcoming the challenges that arise in Part D than were invested in the drug card. Finally, while some of the stakeholders' comments reported here were specific to the new challenges posed by Medicare drug benefits, other comments reflected more general and familiar concerns.

1. Introduction

The Medicare Prescription Drug Benefit

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created a new voluntary Medicare prescription drug benefit in two distinct phases, the interim phase being the implementation of a prescription drug card and transitional assistance program in Spring 2004, and the mature phase being the Part D drug benefit beginning on January 1, 2006. This two-phased program represented a significant expansion of Medicare and an initiative where private entities worked directly with the Centers for Medicare and Medicaid Services (CMS) to offer a benefit on its behalf.

The transitional assistance program (TA) offered $600 of annual Federal assistance that could be applied directly to the cost of prescription drugs for beneficiaries whose income did not exceed 135 percent of the Federal poverty level and who did not have drug coverage through Medicaid, employer-sponsored insurance, Federal employee health benefits program (FEHBP), or TRICARE. This benefit was administered via the drug card program, greatly enhancing the value of the drug cards for eligible beneficiaries.

There are notable similarities between the drug card program and the Part D drug benefit that is currently being launched. Both programs 1) invite the private sector to deliver a public benefit and seek to encourage competition among plans as a way to maximize program value, 2) involve choice on the part of beneficiaries in terms of both whether to enroll and which drug card/plan to choose, and 3) engage similar organizations (health plans, insurers, pharmacy benefits managers, pharmacies, manufacturers, organizations serving beneficiaries, and the States).

Evaluation Purpose and Overview

The purpose of the project entitled "Evaluation of the Medicare Prescription Drug Card and Transitional Assistance Program: Stakeholder Analysis, Phase II Report" is to support the Medicare drug benefit initiative by documenting and analyzing the experiences and perceptions of four stakeholder groups (card sponsors, pharmacies, manufacturers, and States), all of whom are also key players in the Part D drug benefit. The evaluation represents an opportunity to extract lessons that can be productively applied to various Medicare initiatives, including Part D.

This current report is the second of two closely related reports; it is Phase II of a two-phase project. Phase I offered a broad overview of stakeholders' early perspectives on the drug card program with a focus on the card sponsors, who represented the heart of the drug card program. The research design for Phase I included individual in-depth interviews with a broad range of stakeholders, site visits to card sponsors, and analysis of secondary data. Most of the data for the Phase I report was collected between November 2004 and February 2005.

In Phase II, we sought to document *changes* in stakeholders' perspectives on the program and what they believed they had learned from participating. Phase II also featured a heightened focus in four areas:

- The experience of community pharmacists

- The experience of State Pharmacy Assistance Programs (SPAPs)
- The implementation of the program at the local level, especially how various community organizations came together to raise beneficiary awareness and promote enrollment
- The portrayal of the program in major newspapers and in newspapers aimed specifically at senior citizens within the case study communities

To respond to our general purpose and our specific areas of focus, the primary data collection component of the Phase II evaluation consisted of the following activities:

- Repeat individual in-depth interviews with 92 individuals including representatives of drug card sponsors, pharmaceutical manufacturers, the community pharmacy sector (sometimes called the chain pharmacy sector), organizations that seek to assist Medicare beneficiaries, and experts
- Individual in-depth interviews with 14 respondents from State Pharmacy Assistance Programs (SPAPs)
- Four community case studies including interviews with various individuals engaged in promoting the program and helping Medicare beneficiaries attain access to prescription drugs
- Four focus groups with community pharmacists

We conducted the interviews, focus groups, and case studies between August and November of 2005.

In addition to analyzing these primary data, the Phase II evaluation also analyzed several secondary data sources including:

- CMS' website
- Card-level enrollment data from CMS' Medicare enrollment database (EDB) and CMS' Health Plan Management System (HPMS)
- Major newspapers and newspapers oriented toward senior citizens in the four case study communities
- Other relevant sources, most notably documents gathered in the course of the case studies

In addition to this evaluation of stakeholder impacts, Abt also assessed the beneficiary impacts of the Medicare Drug Discount Card program. This study on the beneficiary impacts examined several topics, including beneficiaries' understanding of the drug card program, their information-seeking and decision-making process, their satisfaction, and patterns in drug card enrollment. The current report will note some similarities and differences between the two sets of findings but will not attempt a full comparison.

Abt's two evaluations were part of a larger effort by CMS to collect information from all the stakeholders involved in the Medicare Prescription Drug Card and Transitional Assistance Program to determine the impact of the program and to derive some lessons for the Medicare Prescription Drug Coverage Program. CMS and Abt Associates have been involved in ongoing communications regarding the findings from the evaluations to provide input into the larger effort.

Overview of the Report

The remainder of this report is organized as follows:

- Chapter 2 describes the methods used for the Phase II data collection and analysis.
- Chapter 3 presents the findings regarding card sponsors. An initial section draws on CMS secondary data to characterize sponsors' experience in terms of the numbers of drug cards and the patterns of program enrollment. The second part of the chapter describes findings from sponsor interviews.
- Chapter 4 offers findings from interviews with chain pharmacy executives, chain pharmacists, and independent pharmacists together with findings from the four pharmacist focus groups.
- Chapter 5 covers findings from interviews with manufacturers.
- In Chapter 6, we present the comments of State Pharmacy Assistance Program (SPAP) officials
- Chapter 7 describes findings from the repeat interviews with service organizations that work on behalf of beneficiaries. The first section of the chapter discusses interviews with State Health Insurance Programs (SHIPs); the second section discusses interviews with other information intermediaries.
- Chapter 8 reports on interviews with representatives of professional associations, defined as organizations that represent provider groups, and on interviews with thought leaders, defined as individuals who pay very close attention to the drug card program but are not direct participants.
- Chapter 9 offers results from the case studies including an analysis of newspaper coverage. The first section of the chapter develops a picture of how the program was implemented at the local level, including how informational resources were used, how organizations did or did not coordinate their efforts, and what was learned about reaching beneficiaries. The second section of the chapter analyzes the newspaper coverage on the drug card program in the four case study communities.
- Chapter 10 is a cross-stakeholder chapter that synthesizes all the Phase II results, highlighting major themes and convergences and divergences of perspectives among stakeholders.
- Finally, Chapter 11 discusses the program's legacy and concludes.

Appendices describing methods, references of respondents, and supporting tables follow the chapters.

2. Methods

This chapter describes the methods used for the Phase II collection and analysis of data from individual interviews, pharmacy focus groups, community case studies, sponsor summaries, and newspapers.

Individual Interviews

Individual in-depth interviews conducted by telephone form the core of the Phase II report. The interviews allowed the Project Team to gather a range of perspectives on the implementation of the drug card program, once the program was well underway.

The Phase I Evaluation Report incorporated individual in-depth interviews with 137 individuals. Phase I respondents were members of the four stakeholder groups (card sponsors, pharmacies, manufacturers, and States) or other individuals with important perspectives regarding the Medicare drug card program. For Phase II of the Study, the Project Team returned to all 137 individuals that participated in Phase I to request their participation in a second interview. The Project Team completed interviews with 92 of these individuals. In addition to returning to all Phase I respondents for the in-depth interviews, the Project Team included an additional stakeholder group: State Pharmacy Assistance Programs (SPAPs). The Team completed 14 interviews with the SPAP group; therefore, 106 interviews were conducted for the Phase II Evaluation. Exhibit 2.1 displays the distribution of Phase I and II interviews by stakeholder group:

Exhibit 2.1
Distribution of Interviews (Phase I and II)

	Phase I	Phase II
Card Sponsors	**32**	**21**
Manufacturers	**16**	**9**
Pharmacies	**39**	**28**
Executives of chain pharmacies	17	10
Pharmacists in chain pharmacies	10	9
Pharmacists in independent pharmacies	12	9
SPAPs	**Not in Phase I of the Study**	**14**
Organizations helping Beneficiaries		
SHIPs	22	11
Information Intermediaries	8	7
Experts		
Thought Leaders	10	9
Professional Associations	10	7
Grand Total	**137**	**106**

All interviews included in the Phase II Final Report were conducted between August 24, 2005 and November 21, 2005.

The Phase II interviews document the most salient features of the drug card program, from the point of view of each set of stakeholders. In addition, the interviews sought to capture stakeholders' perspectives on specific topics of interest to CMS. Many of the topics were relevant to all of the stakeholder groups, while others pertained to individual groups.

Exhibit 2.2 shows the major research topics and the associated stakeholder groups who were interviewed about these topics.

Exhibit 2.2 Major Research Topics and Associated Stakeholder Groups, Phase II

	Sponsors	Manufacturers	Pharmacy Executives	Chain Pharmacists	Independent Pharmacists	SPAPs and State Officials	SHIPs & Info Intermediaries
Background	X	X	X	X	X	X	X
Background, including plans for Part D	X	X	X	X	X	X	X
Major changes in approach to drug card program during 2005	X	X	X	X	X	X	X
Overall Experience	X	X	X		X	X	X
Impacts	X	X	X		X	X	X
Overall Experience with CMS	X	X	X		X	X	X
Role of Chain Pharmacy Sector in Helping Beneficiaries with Drug Benefits & Costs			X	X	X		
Experience Reaching the Target Population	X	X	X	X	X	X	X
Reaching target population: Suggestions for CMS	X	X	X	X	X	X	X
MSP Program	X						
Experience with Enrollment & Beneficiary Choice	X	X	X	X	X	X	X
Tools and resources to support choice	X	X	X	X	X	X	X
Experience with State / Federal Partnerships: Enrollment						X	X
Experience with State / Sponsor Partnerships	X					X	
Experience with State / Federal Partnerships: Coordination of Benefits						X	X
Experience with Sponsor / Manufacturer Partnerships: Coordination of Drug Cards and Manufacturer PAPs	X	X					
Experience with CMS Communications	X	X	X	X	X	X	X
Information for own decision-making	X	X	X		X	X	
Information to support beneficiary decision-making			X	X	X	X	X
Closing Questions	X	X	X	X	X	X	X

Professional associations and thought leaders were asked subsets of these questions relevant to the sector they represent / their area of expertise.

Interview procedures were designed to create an objective and accurate documentation of stakeholder perspectives. During Phase I, the Project Team identified a representative source of potential respondents and created an initial sample for each of the major stakeholder groups. The Project Team returned to the Phase I respondents for Phase II and used the same model to develop the SPAP sample for Phase II. (Appendix A offers more detail about the development of interview samples and other issues related to interview procedures.)

The Project Team developed a discussion guide based on the topics in Exhibit 2.2. The discussion guide used open-ended questions to elicit information from respondents on these topics. Both the discussion guide and interviewers' follow-up questions were designed to emphasize changes in approaches, changes in perspectives, and lessons learned. The entire discussion guide appears in Appendix B. Individuals were also invited to provide additional comments at the end of the interview.

All respondents were promised full confidentiality except for professional associations and thought leaders. These two groups were asked for permission to include their name (thought leaders only) and the name of their organization in an appendix.

Interviews were conducted by telephone[4] by one or two project staff members. Interviewers took notes during the interview and confirmed their understanding of essential points with the respondent during the interview. Immediately after the interview, one of the interviewers created a written summary of the interview using a standard format. These summaries were assembled into an NVivo database.[5]

The Project Team analyzed the summaries. Initially, the data were coded according to structural codes that mirrored major sections in the protocol and were similar for all interview groups. Staff then identified precisely defined themes for each stakeholder group. Project Team staff examined how many times each theme was raised by respondents, to add rigor and objectivity to the process of documenting widely held views.

In chapters that describe findings from sponsors, the community pharmacy sector, manufacturers, SPAPs, and organizations serving beneficiaries, we discuss primarily themes that were raised by three or more respondents, occasionally mentioning a significant theme that was raised by one or two respondents. Thought leaders, respondents at professional associations, and case study respondents are treated differently because these groups were not homogeneous. These chapters include more points made by only one person if these points fit with project themes.

Community Case Studies (Including Analysis of Newspaper Coverage)

In Phase II of the study, the individual in-depth phone interviews were supplemented by community case studies. Four community case studies were designed to understand how the drug card program worked at the community level. We wanted to understand better how local, national, and other resources were used; whether there was coordination among various stakeholders, such as SHIPs counselors, CMS representatives, States, SPAPs, and other community-based organizations; what

[4] Two interviews with SPAPs were conducted on-site during the Community Case Study visits, rather than on the telephone.

[5] NVivo is a software product used for qualitative data analysis.

kind of support local information providers needed and received; what these stakeholders had learned about beneficiary responses and other issues from the drug card program; and how the drug card program experience has shaped the respondents' approaches to the introduction of Part D.

The four communities were selected to create diversity across four dimensions: region of the country, urban or rural community, whether an SPAP existed, and the nature of the local communication campaign. The Project Team also reviewed the selected options with knowledgeable individuals within the CMS Regional Offices and, when possible, the State SHIP office. The CMS Project Officer and the Project Team worked together to make the final selections for the communities. The names of the communities are not listed in this report to guarantee respondents' confidentiality.

To gather the appropriate sample of potential respondents in each community, we identified the SHIPs, key information intermediaries, the SPAP representative (if applicable), and other organizations involved in raising awareness and conducting outreach to beneficiaries on the drug card program. Additional respondents were identified using a "snowball" model, i.e., we spoke with informed individuals, such as State SHIP leaders, who could refer us to possible key respondents, who could then refer us further on, and so forth. We contacted individuals by email and telephone, sent project descriptions, which briefly discussed their potential involvement as appropriate respondents, and requested their participation in the Study. Individuals who agreed to participate were scheduled for appointments with the Project Team.

Two members of the Project Team participated in each case study, spending approximately two full days at each location. At least eight interview discussions were held at each location, using the same discussion guide as the in-depth interviews but with a more flexible interview structure and an emphasis on how the program played out at the community level.

As part of the case studies, we analyzed how the newspapers in each of the case study communities presented the drug card program. We identified the mainstream newspapers in each community, used an electronic keyword search to find articles that mentioned the drug card program, and then categorized each article according to time period, topic, tone, theme, and other attributes. Two communities also had what we termed "senior publications," monthly newspapers oriented specifically towards seniors. We also incorporated those senior publications into our analysis.

Pharmacy Focus Groups

Phase II added an increased emphasis on pharmacists' experience with the drug card program by holding four focus groups with pharmacists. The focus groups were held in September and October 2005. The target population for these focus groups was chain and independent pharmacists in two of the four community case studies. The Project Team acquired a list of pharmacists practicing in community pharmacies; we then created a sample of individuals whose titles indicated they were pharmacists, as opposed to pharmacy technicians or managerial personnel. In the case of independent pharmacists, individuals whose titles indicated that they were owners were prioritized. All respondents in the focus groups were screened to ensure that they had handled or discussed the Medicare drug card program with Medicare beneficiaries at least twenty times during the program.

In both of the communities, the Project Team conducted one focus group with independent pharmacists and one with chain pharmacists, for a total of four focus groups, with the following numbers of respondents:

- Independent pharmacists, Community 1, (1 group, 10 respondents)
- Chain pharmacists, Community 1 (1 group, 12 respondents)
- Independent pharmacists, Community 3 (1 group, 9 respondents)
- Chain pharmacists, Community 3 (1 group, 10 respondents)

The Project Team developed the focus group discussion guide in conjunction with the in-depth interview guide. The focus group discussion guide, presented in Appendix C, included lines of inquiry similar to the Phase II in-depth interview guide and also incorporated interview topics of interest to CMS from the Phase I interview guide.

Secondary Data on Card Sponsors

In Phase I, the Project Team created a summary of each individual card sponsor using secondary sources and a standardized template. These summaries were delivered to CMS as a freestanding report. In addition, the Phase I evaluation report drew on these summaries to offer an overview of the universe of drug cards. In this Phase II report, we update and expand upon key aspects of that overview and comment on how the universe of cards and the levels of program enrollment changed between July of 2004 (the period on which the Phase I summaries were based) and July of 2005.

The Phase II analysis of secondary data on card sponsors draws on data from CMS' individual-level Medicare enrollment database (EDB), the CMS website, and CMS Health Plan Management System (HPMS).[6] The unit of analysis was the individual Medicare-approved drug discount card.

Limitations of the Research Design

The research design had two notable limitations. The first was the potential for selection bias. While we make every effort to ensure that the sample of individuals invited to participate in interviews, focus groups, and case studies would represent the relevant wider population, the decision to participate in the research was voluntary. Individuals who had more time or who believed that they have important messages to convey to CMS were potentially more likely to talk to the Project Team than individuals who had less time or who believed they had less to say. Our findings may be subject to selection bias, if the individuals who ultimately participated in the research were not a representative sample of the desired population.

The second limitation was that the project objective was to emphasize *changes* in stakeholders' approaches and perspectives between the time of the Phase I data collection (November 2004-February 2005) and the time of the Phase II data collection (August – November 2005). While interview questions focused on changes and the second year of the drug card program, many respondents answered with general observations and repeated themes from Phase I; they thought of the program as a single whole and, in general, had not changed their approaches or perspectives between the two time periods. The mismatch between the project's objectives and respondents' way of thinking created challenges in analyzing the data. Our approach was to note all the themes that arose in Phase II and to determine whether they were repeat themes, new themes, or reflected a

[6] The EDB data was accessed on July 23, 2004 and July 25, 2005; the HPMS data was accessed on June 23, 2004 and March 9, 2005.

change in emphasis or evolution of perspective between the two time periods. The report describes repeat themes briefly and new and changed themes in more detail.

3. Results: Sponsors

This chapter presents sponsors' experiences with the drug card program. The first section uses secondary data to characterize sponsors' experience in terms of the number of approved drug cards in 2004 and 2005, the fees charged by those cards and the levels of program enrollment. The second section describes the comments made by respondents from 21 sponsors in interviews.

3.1. Analysis of Secondary Data

Number of Medicare-Approved Drug Cards

Exhibit 3.1 displays the number of Medicare-approved drug cards in 2004 and 2005. This data show that the number of drug cards were relatively stable between 2004 and 2005. Of the total 155 Medicare approved cards in 2004, 73 were general cards and 82 were exclusive cards, corresponding to 47 percent and 53 percent of all drug cards respectively. Of the 166 total drug cards in 2005, 73 were general cards and 93 were exclusive cards, representing 44 percent and 56 percent of all cards respectively.

Between 2004 and 2005, two exclusive cards were discontinued and 13 new exclusive cards were approved, resulting in a net increase of 11 cards between 2004 and 2005.[7]

Exhibit 3.1

Number of Drug Cards by Year

	2004	2005	Discontinued	New Cards	Net Change
Total	**155**	**166**	**2**	**13**	**+11**
General	**73**	**73**	**0**	**0**	**0**
National	31	32	0	**	+1
Regional	32	32	0	0	0
National & Special Endorsement	8	7	**	0	-1
Special Endorsement	2	2	0	0	0
Exclusive	**82**	**93**	**2**	**13**	**+11**

Based on all approved drug cards.

** One card changes its status from a national and special endorsement card to a national card between 2004 and 2005
Sources: CMS Website 06/23/2004 & 03/09/2005

Fees

Sixty-five drug cards (general and exclusive) in 2004 and 2005 charged enrollment fees. This represented 42 percent of drug cards in 2004 and 39 percent of drug cards in 2005. Eighty-four percent of general cards in both years charged enrollment fees. The average fee for general cards was $23.22 in 2004 and $23.29 in 2005.

[7] The general cards were the same cards in both years.

Four exclusive cards in the two years charged enrollment fees. In 2004, the four fee-bearing exclusive drug cards all charged a $30 enrollment fee; in 2005, the average fee for exclusive cards dropped by a third from $30 to $19.06. Three of the four fee-bearing exclusive cards changed their fees between 2004 and 2005. One card changed from a $30 fee to a sliding scale of $0 -$2.50 fee. A second card changed from a $30 fee to a sliding scale of $0-$30. A third card dropped its $30 fee completely.[8] Additional detail is presented in Appendix D: Exhibit D.1.

Overall Enrollment Levels 2004 and 2005

Between 2004 and 2005, overall enrollment in Medicare-approved drug cards increased by 69 percent, from 3.85 million beneficiaries (3.85M) in 2004 to 6.5M in 2005. Exhibit 3.2 shows the total enrollment of drug cards by year and by type. Enrollment by TA eligible beneficiaries increased at a greater rate (126 percent) than enrollment by non-TA eligible beneficiaries (53 percent).

Between 2004 and 2005, overall enrollment in general cards almost tripled, with enrollment increasing by 177 percent, from 1.36M to 3.77M. General card enrollment by non-TA eligible beneficiaries increased at a greater rate (221 percent) than enrollment of TA eligible beneficiaries (136 percent).

Between 2004 and 2005, enrollment in exclusive cards increased by 10 percent, from 2.49M to 2.73M. However, there was a notable increase in enrollment of TA eligible beneficiaries into exclusive cards (81 percent) from 139,000 to 252,000. Some of this increase may represent beneficiaries who were auto-enrolled into exclusive cards and then later recognized that they were also able to take advantage of the $600 credit. During this period, enrollment of non-TA eligible beneficiaries increased by about six percent.

Exhibit 3.2

Total Enrollment in 2004 and 2005

	2004	2005	Percent Change
All Drug Cards	**3.85M**	**6.50M**	**69%**
TA Enrollment	.831M	1.88M	126%
Non-TA Enrollment	3.02M	4.62M	53%
General Cards	**1.36M**	**3.77M**	**177%**
TA Enrollment	.692M	1.63M	136%
Non-TA Enrollment	.667M	2.14M	221%
Exclusive Cards	**2.49M**	**2.73M**	**10%**
TA Enrollment	.139M	.252M	81%
Non-TA Enrollment	2.35M	2.48M	6%

Based on enrollment in all drug cards.
Sources: Medicare enrollment database – 07/23/2004 & 07/25/2005

[8] For the two cards with sliding scale fees, the mid point of the sliding scale was used when calculating average fees for all exclusive cards.

3.2. Interviews

This section of the sponsor chapter describes and summarizes comments made by sponsors in the in-depth interviews.

Description of Respondents

This chapter is based on interviews with respondents from 21 organizations that sponsor general and/or exclusive Medicare-approved drug cards. These 21 organizations included:

- Seven pharmacy benefits managers (PBMs)
- Eight health plans/managed care organizations (MCOs)
- Two pharmacy benefits administrators (PBAs)
- Two insurance companies
- Two state-level philanthropic organizations specializing in drug benefits

Of the 21 organizations, there were thirteen organizations sponsoring at least one general card, ten Medicare Advantage (MA) plans sponsoring at least one exclusive card, and one sponsor offering a special endorsement long-term care card. Four organizations offered both general and exclusive cards.

Among the respondents from general card sponsors, 12 identified themselves as involved in lines of business associated with new business or government programs and others included pharmacy directors, an executive director, and vice presidents or directors of operations. Among the respondents from exclusive card sponsors, most described their role with the Medicare drug card program as compliance officers or product managers. One was a chief operating officer, and another was an executive director. Six respondents had been promoted, and a number of others had broadened their scope within their respective companies since the drug card implementation. Many respondents were actively involved in leadership roles for Part D.

Changes in Approach to Drug Card During 2005

The majority of plans reported **no change in their approaches** to the drug card program during 2005, although several noted that their enrollment had increased between the two interviews. Many reported that their attention had moved on to other things, such as the Part D program.

Overall Experience, Impacts, and Lessons Learned

Overall Experience and Impacts

When asked to reflect on their organization's experience with the drug card program as a whole and on the program's impacts on their organization, many respondents remembered that **it had required a major effort to get the program up and running**; this was also a major theme in Phase I. Several emphasized that the fact that the program had evolved and changed over time had added to the operational complexity.

Echoing Phase I, almost half of the sponsors explicitly mentioned effects on their information technology departments, with several suggesting that these effects had been significant in terms of

resources required. Similarly, about half mentioned that the new program required increases in staffing. In a few instances, the initial increases in staffing during the start-up period were followed by the need to decrease staff in later phases.

Eleven of the 21 sponsors stated, unprompted, that they had not made money on the drug card program; sponsors also indicated that financial impacts had been negative in Phase I. Several expressed disappointment or frustration with the financial results. Several sponsors expressed disappointment with enrollment levels, including the response to the MSP program.

In late 2004, sponsors reported that one of their two top reasons for participating in the drug card program was to offer a benefit to members, notably the $600 credit. In 2005, about **half of sponsors expressed personal and organizational satisfaction because the drug card program had offered the opportunity to "do the right thing" and to provide a valuable benefit to members via the $600 credit.** For example, one respondent said that it was very rewarding for her staff to hear the heartfelt "thank-yous" from beneficiaries.

Lessons Learned

In addition to these immediate impacts, **many card sponsors acknowledged that the drug card had been a learning experience for Part D**; in Phase I, this had been a key reason for participating in the program. Moreover, sponsors stated that they had acquired valuable insights into internal operations, collaborating with partners such as manufacturers and pharmacies, working with CMS, and operating with retail and institutional customers. When asked to expand upon lessons learned, sponsors noted the following in the areas of internal operations and working with partners:

- Changes to organizational structure. One firm added a new unit responsible for CMS-type programs.
- Insights and innovations in capturing information and communicating internally, such as strategies for monitoring the CMS website and educating members of their organization about the new programs.
- Increased capability in project planning and management, such as flow charts and timelines.
- Increased formalization of planning processes.
- Development of specific internal capabilities, such as contracting with PBMs, manufacturers and pharmacies; claims adjudication; and working with ICD-9 codes.
- Improved record keeping in response to CMS' need for documentation.
- Strengthened ability to be flexible and respond to change.
- Expanded networks of partners and consultants.

Experience with CMS

Echoing a theme from 2004, many sponsors praised CMS staff for having a good attitude and working hard under challenging circumstances. Several explicitly mentioned that they called CMS staff after hours or on weekends and found them at their desks. They were positive about the card manager system and the sponsor conference calls; respondents implied that these should be maintained for Part D. **Sponsors applauded CMS' commitment to beneficiaries, flexibility, sponsor communications, and openness to sponsors' suggestions and comments.**

In Phase I, many sponsors suggested that the implementation process would have been smoother and more efficient if CMS had sought input from them. In both phases of the project, sponsors commented that CMS staff were over-stretched and lacked necessary expertise, experience, and resources and that these deficits created challenges for the sponsors. In Phase II, several remarked that CMS had become much more collaborative over the life of the drug card program. Repeating themes from Phase I, several respected the fact that **CMS had succeeded in launching the program on the very tight timeline required by law.** Several noted that the conference calls improved over time with the assistance of a CMS contractor. Several simply cited a positive relationship or said that CMS had done a good job.

Echoing a theme from Phase I, several exclusive sponsors observed that CMS' guidance often appeared to be oriented toward general card sponsors. Some sponsors believed that CMS' orientation did not clearly and carefully address the needs and situations of the sponsors of exclusive cards.

In terms of lessons learned, a major lesson seemed to be a revised set of expectations regarding working with CMS**. Some sponsors reported that they had learned patience and tolerance through the process.** Others were more explicit: they expected changes to documents even when they were marked final; they prepared for CMS to miss self-imposed deadlines; and they knew that CMS would not be able to respond to all their questions and needs. Sponsors remarked that they now built excess capacity into their systems in order to handle late-emerging requirements or that they worked at a logical pace and did not align themselves too closely to CMS' published timelines.

Experience Reaching the Target Population

When asked about their experiences trying to reach the target population, several general card sponsors reiterated a Phase I theme: beneficiaries were hard to reach. They continued that beneficiaries were confused about the drug card program and that they were distrustful of government programs in general and of the sponsors themselves, particularly due to belief that the drug card program might be some sort of scam. One additional challenge surfaced in Phase II: **three sponsors mentioned that some beneficiaries did not wish to admit that they had low incomes. Two also noted that the difficulty of the income-verification process posed a barrier to enrollment.**

Several sponsors reported that they did not make additional efforts to market their drug cards in 2005, but about a **third of sponsors described continuing marketing efforts that used one-on-one approaches to reach seniors, typically via the telephone.** Two mentioned calling potential new members and allowing plenty of time to talk; several others fielded incoming calls with patient staff who were ready to explain the fine points of the program one-on-one.

By Phase II, sponsors had developed a **clear sense of effective strategies** for reaching the target population; many of these strategies were learned or reinforced as a result of the drug card program:

- **Communicate on an ongoing basis and use multiple modes**.
- **Prepare for one-on-one conversations that address the beneficiary's unique concerns and situation, and allow plenty of time.** In some cases, these conversations took place in person although phone was the most typical mode. One respondent believed that the key to his organization's success had been that beneficiaries got a person and not a phone menu when they called.

- **Reach out to beneficiaries' children and other agents of the beneficiary**, such as Serving Health Insurance Needs of Elders (SHINE) representatives.
- **Find co-branding or community partners** that beneficiaries know and trust and reach beneficiaries through these partners.
- **Do not solely rely on the Internet** to reach this population.
- **Make messages simple, clear, and concise**. Use terms that beneficiaries can understand. Over half of sponsors highlighted this point; several specifically added that CMS' materials were too long and that the language was too technical.
- **Recognize the special needs of the target population**, by using larger fonts, translating materials to other languages, and hiring multi-lingual staff.
- D**o not expect beneficiaries to understand the Federal drug benefit**. Plan to explain the basics of the program as well as the particular product being marketed.

When asked specifically about experiences reaching low-income populations, sponsors underscored that this population was extremely hard to reach and to enroll; several were amazed by the low rates of enrollment among populations eligible for subsidies[9]. To explain these challenges, sponsors noted that, relative to the general population, low-income beneficiaries often had the following: lower access to information sources such as television and the Internet; moved more often; were more likely to not be fluent in English; and were more likely to be visually and cognitively impaired. Despite the differences between low-income and other beneficiaries, sponsors believed that the strategies for reaching low-income populations were the same as those needed for the target population as a whole; some of the suggestions are listed above.

Seven sponsors had participated in the second round of the MSP program; these sponsors had mixed views of this experience.

Experience with State / Sponsor Partnerships

Six sponsors were able to comment on experiences working with State Pharmacy Assistance Programs (SPAPs) as part of the drug card program. Four explicitly stated that auto-enrollment worked well.[10]

Experience with Sponsor / Manufacturer Partnerships

Seven sponsors commented on the coordination of the Federal drug card program and the manufacturer pharmacy assistance programs (PAPs), which offer reduced price drugs to qualifying individuals. Two stressed that the **coordination of these programs was of great value to beneficiaries, especially those taking high-priced drugs.** According to two sponsors, these programs were challenging to administer because of the need to separately contract with each

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[9] In the drug card time period, many low-income Medicare beneficiaries were eligible for drug benefits through Medicaid and were thus not eligible for TA. Under Part D, this group of low-income beneficiaries will be eligible for the coverage via the private drug plans and will be effectively reached through their existing relationship with state Medicaid programs and through plans to enroll them automatically into a part D private drug plan, if they do not enroll voluntarily.

[10] Consistent with this finding, Abt's evaluation of the Medicare drug card's beneficiary impacts found that there was a relative increase in participation in the drug card program and in transitional assistance in states with auto-enrollment.

manufacturer, which meant that each program had to be individually incorporated into the sponsor's systems.

Information Needs, Sources, and Gaps

Drug Card Program, Information for Own Decision Making

We asked sponsors what information they had needed in order to make initial decisions about participating in the drug card, a topic not addressed in Phase I. Several cited the need for implementation details and guidance; several said that they made the decisions to participate based solely on the need to build a base for Part D.

In response to questions about their sources of information, sponsors mentioned the law and regulations through CMS sources including the RFP and Frequently Asked Questions, the CMS website, the weekly conference calls, and personal contacts at CMS (especially the card managers). Several also mentioned professional organizations such as Blue Cross and the trade organization America's Health Insurance Plans (AHIPs).

Some sponsors cited gaps in the information available at the time the drug card program was launched, noting gaps pertaining to operational issues, requirements for preferred drugs lists, and reporting requirements. Sponsors noted that they lacked a clear sense of what guidance applied to exclusive card sponsors. Some thought the available information was late, inconsistent, excessively lengthy, or poorly indexed. Several also said that CMS had done a good job and either that there had not been gaps or that any gaps had been oversights and addressed as quickly as possible.

Part D, Information for Own Decision-Making

Sponsors were asked about information needs, sources, and gaps with regards to the decision to participate in Part D. Many sponsors did not offer detailed answers to this question; some sponsors decided not to participate in Part D due to a lack of appropriate capacity; others were managed care plans that had made an immediate decision to participate. Broadly speaking, sponsors named the same sources of information for Part D that they had named for the drug card.

Sponsors did note some gaps in their information regarding Part D. At the time of the interviews, they needed more information concerning compliance requirements, support on COB, how to calculate beneficiaries' true out-of-pocket expense (TROOP), enrollment procedures, and reporting requirements. Sponsors also wished to clearly understand which guidance did and did not apply to Medicare Advantage Private Drug Plans (MA PDPs).[11] In response to this question and at other points, many sponsors expressed a concern that CMS' guidance could never be trusted to be final or complete, because the potential for revision and change always existed.

Plans for Part D

Of the 21 respondents, ten were planning to sponsor either a private drug plan or an MA-PDP in 2006. Of the remaining eleven, seven noted, unprompted, that they would be partnering with or supporting other Part D plans.

[11] Most sponsor interviews were conducted between September and November 2005; in some cases, a sponsor may have found the information they needed shortly after the interview.

Discussion

In late 2004, when asked about their reasons for participating in the drug card program, most often sponsors mentioned offering a benefit to members (notably the $600 credit) and preparing for Part D. During the Phase I interviews, many commented at length on the challenges of program participation. When asked to characterize their experiences working with CMS in Phase I, sponsors recognized that CMS staff worked hard and that implementing the drug card program was a challenging task. However, many sponsors were critical of the way the program had been implemented.

A year later, consistent with their reasons for participation, many sponsors described the **drug card program as an opportunity to do the right thing for beneficiaries and as a learning experience for Part D.** They continued to acknowledge that the drug card program had required a major effort and had typically not been a profitable endeavor. In general, the sponsors had met their non-financial goals for participation, although the financial outcomes remained disappointing.

In Phase II, sponsors continued to **praise CMS for having a good attitude and working hard, but they continued to believe that CMS lacked some of the capacities necessary for program oversight**. Some sponsors were very positive about the way **CMS had evolved over the life of the program; they said that CMS had become more collaborative**. As a result of their experiences working with CMS on the drug card, respondents believed that they were **better prepared for Part D** because they knew what to expect and made their plans accordingly.

While many themes persisted from Phase I into Phase II, in the later period, **sponsors no longer had the intensity of feeling** that had characterized their comments in the first round of interviews; most of the obstacles had been overcome and the memory of the associated challenges had receded.

4. Results: Community Pharmacy Sector

This chapter describes findings from interviews with chain pharmacy executives, chain pharmacists, independent pharmacists, and findings from four pharmacist focus groups.

4.1. Interviews with Executives

Description of Respondents

In Phase I, executives at 17 chain retailers participated in interviews. A majority of these were companies whose core business was community pharmacy, but several grocery store and mass merchandise chains were included, as well as one warehouse discount club. In Phase II, ten of the Phase I chain pharmacy executives participated in follow-up discussions. Two pharmacy chains from Phase I had merged, so a combined representative responded in Phase II. The respondents were directors and vice-presidents of the chain pharmacy sector. Respondents primarily had the responsibility of oversight of the prescription drug card program and Part D.

Changes in Approach to Drug Card During 2005

Nine of ten respondents reported **limited or no changes in their approaches** to the drug card program. In fact, during 2005, several mentioned clearing counter space of materials relating to the drug cards to make room for materials involving Part D. A few pharmacy executives mentioned that as the program progressed, it was easier for their pharmacists to help beneficiaries because the pharmacists had been advised on which drug discount cards to recommend to their customers.

Overall Experience, Impacts, and Lessons Learned

Overall Experience and Impacts
Eight of ten respondents reported **little to no impact of the drug cards** on their business. Respondents cited a variety of reasons including the low enrollment in the drug card program. Four respondents acknowledged a modest, but limited, decrease in their cash business as some customers used the drug cards. A few respondents believed that by accepting most or all of the drug cards that were offered in any given region, they would maintain their customer base. This was stated as the main reason for participation in the program during Phase I interviews.

Lessons Learned
Pharmacy executives reported few lessons learned from the drug card program. A few pharmacy executives thought the program's value was that it allowed their company to prepare for Part D by learning about contracting, internal systems development, staff training, and working with CMS.

More than half of the respondents said they learned little or nothing concerning low-income populations and subsidized benefits. Similar to the Phase I responses, five respondents mentioned the **difficulties of outreach and enrollment** associated with the low-income population. Several respondents discussed that the outreach programs were ineffective in reaching the low-income beneficiaries most in need of financial assistance and cautioned that these problems would remain under Part D.

Nine respondents expected, given their experience with the drug cards, to encounter significant problems at the pharmacy counter during the first months of the Part D program. At the time of the interviews, respondents believed that the logistical complexities inherent in the drug card program and its multi-card structure would persist into the Part D program.

In light of expected problems with the Part D program, respondents responded proactively and adopted several methods to improve their outreach and target their activities. Activities included producing and disseminating senior oriented and simple marketing materials earlier, conducting a variety of senior outreach programs (in-store events and at senior centers), providing education to more staff, and using a structured policy to direct seniors toward the correct informational resources.

Experience with CMS

Several respondents said that they had **little or no contact with CMS** during the drug card program. Many respondents who did have contact with **CMS complimented the agency for improving their services and collaboration activities since Phase I. Respondents acknowledged improvement in CMS' responsiveness and listening to the pharmacy sector**. Respondents stated that CMS's culture had evolved toward one with a **more collaborative posture**: one that listens more attentively. Some respondents mentioned the **continued improvement in marketing materials** published by CMS.

Even though many of the respondents remain critical of the pharmacy benefit managers' (PBMs) influence over the planning of Part D, respondents praised CMS for including the chain pharmacy sector in the design of the Part D program. Three respondents criticized the level of CMS staff preparedness and expertise around Part D, but several complimented CMS staff for their hard work and level of preparation.

Role of Community Pharmacist in Helping Beneficiaries with Drug Benefits and Costs

Nearly all of the chain pharmacy executives believed that the fundamental role of the community pharmacy sector was to provide accurate and helpful information to their customers. Eight respondents said their chains did not plan to help beneficiaries enroll in a Part D plan but did plan to guide beneficiaries to the right resources, such as the Medicare website, the CMS toll-free helpline, and a list of approved plans. **Even though the respondents were not planning to assist beneficiaries in enrolling in Part D, most believed that pharmacies *should* be able to provide guidance concerning which plan to choose and enrollment assistance.**

Experience Reaching the Target Population

Nearly every chain pharmacy executive reported that their pharmacy counters had displayed brochures and handouts about the drug card program since its inception. Several also hosted informational sessions and performed some community outreach. During 2005, drug card program's promotional efforts had nearly ended. Respondents pointed to a low enrollment in the program, a lack of beneficiary interest, and a desire to avoid confusion with the Part D launch as reasons that they stopped promoting the drug card program.

Pharmacy executives reported that they did not learn a great deal on reaching the target population through the drug card program. Respondents attributed the lack of learning to already knowing how to reach the population or because the strategies they tried were unsuccessful.

Experience with Enrollment and Beneficiary Choice

Half of the chain pharmacy executives reported little or no efforts to support customer choice and enrollment in the drug card program. Four offered information but did not provide particular guidance in choosing among the drug cards; three respondents provided explicit advice and recommendations. To prevent a situation in which the beneficiary would blame the pharmacist if the choice turned out to be unsatisfactory, four respondents believed that pharmacists should not give beneficiaries advice about the choice of card. However, consistent with a Phase I theme**, three other respondents believed that providing straightforward explanations, set of choices, and advice about how to choose is the best way for pharmacists to support beneficiaries.**

Information Needs, Sources, and Gaps

Drug Card Program, Information for Own Decision Making

More than half of the executives cited data on formularies, payment, and contractual arrangements as the most essential information needed in order to make decisions about participating in the new program. In addition, respondents mentioned needing a variety of administrative information on topics such as coordination of benefits, SPAP rollovers, claims adjudication processes, and the administration of the transitional assistance (TA). Four cited a need to understand the drug cards' marketing materials prior to disseminating them to beneficiaries. Respondents received almost all of their data from sponsors, the CMS website, and the National Association of Chain Drug Stores (NACDS).

While three respondents reported no gaps in the information provided for the drug card program, several respondents pointed to problems with the information available from CMS and the sponsors. These problems included the CMS website being poorly targeted, difficult to navigate, or inaccurate; significant delays in getting information from both CMS and the sponsors; and sponsors' marketing materials being inaccurate. Four respondents stated that their companies had created their own marketing and informational materials to distribute to customers.

Part D, Information for Own Decision Making

Respondents relied on CMS, sponsors, and NACDS, for information on Part D. At the time of the Phase II interviews, every respondent cited needs for similar information for Part D to that which they needed for the drug cards, such as an approved plan list, formulary information, benefit design, and eligibility data (it is unclear what was available). Several applauded the improvement in both the CMS' website and CMS' marketing and educational materials associated with the Part D rollout.

Plans for Part D

Most of the respondents reported that their pharmacists would not offer guidance to beneficiaries concerning Part D; some said their pharmacists would help beneficiaries with the application process. Most respondents stated that they would offer basic information, with referral to other resources for more detailed facts.

To educate their customers, all pharmacy chains had developed Part D handouts, brochures, and marketing materials specific to Part D; the materials were similar to their drug card information resources. Most respondents had developed or implemented formal staff education and training, often with some continuing medical education (CME) credits involved. Respondents conducted a variety of Part D activities including actively participating in outreach programs, developing enrollment assistance programs to help customers choose and enroll in the right plan, contracting with the relevant prescription drug plans (PDPs), increasing their staffing and operational capacities, and gathering various materials including PDP marketing information on all approved plans in that region. Three respondents decided to carry out limited activity around Part D, such as contracting with relevant PDPs and waiting for the rollout of the Part D program. Two of these three respondents were larger general retailers whose primary product line was groceries or other household products.

Discussion

In Phase I, chain pharmacy executives reported that their main reason for participating in the drug card program was to serve existing clientele. In Phase I, this sector felt a strong sense of anger, frustration, and victimization. A strong majority of respondents reported that CMS made no effort to communicate with them about the program; in fact, many thought that other stakeholder groups, such as the manufacturers and PBMs, were consulted more closely.

In Phase II, chain pharmacy executives reported low enrollment among their clientele. While most were disappointed with this low enrollment, **some respondents were relieved because the profit margins were typically lower for customers with Medicare drug cards than for those without drug benefit cards.** In Phase II, chain pharmacy executives expressed **concern about the potential burden due to Part D on their staff**, as a much larger number of Medicare beneficiaries will attempt to enroll in private drug plans and learn how to use their new benefits.

In Phase II, many of the Phase I themes were reiterated, but the intensity of the feeling has dissipated. Furthermore, most of the chain respondents believed that CMS worked very hard and, relative to the drug card, had started focusing on Part D much earlier, had provided more timely and higher quality information, and had become more responsive to stakeholders' comments and needs; these were improvements by CMS and seemed to be responses to chain executives Phase I suggestions. While in Phase II there was some frustration at the influence of the PBMs and a concern that confusion among customers will not abate under Part D, there was a far greater sense that CMS was trying harder and were succeeding in their efforts.

4.2. Interviews and Focus Groups with Pharmacists

Description of Respondents

This chapter is unique because it discusses results not only from interviews with pharmacists but also from focus groups with additional pharmacists. The 18 in-depth interviews were conducted with 9 independent pharmacists and 9 chain pharmacists. The four focus groups had a combined 19 independent pharmacists and 20 chain pharmacists.[12]

[12] See Section 2 Methods for details on the selection process and data collection methodology.

For the telephone interviews, all but one of the 18 pharmacists participated in Phase I.[13] All independent pharmacists worked for independent pharmacies and the majority of them were the managers and/or storeowners. All chain pharmacists worked for chain pharmacies and were the pharmacy managers.

The focus groups were conducted in two of our case study communities.[14] In the focus groups, we covered a majority of the same topics as the interviews. In addition, we asked pharmacists about themes unique to the focus group protocol: benefits of the drug card program, experiences checking the transitional assistance (TA) balance, coordination of benefits, roles in helping beneficiaries understand the drug card program and questions asked of pharmacists about the program, factors affecting beneficiaries' decision to enroll in a drug card, and anticipated challenges during the transition from the drug card program to Part D. For the focus groups, there were 22 pharmacists from Community One and 17 pharmacists from Community Three. Independent pharmacists participating in the focus groups were primarily storeowners and chain pharmacists were practicing pharmacists.

Changes in Approach to Drug Card During 2005

Several of the pharmacists in both the interviews and focus groups reported **no changes in their approaches** to the drug card program during 2005. A few mentioned that they were no longer thinking much about the drug card program and were completely focused on Part D. During 2005, a few pharmacists actively helped their customers select a drug card that covered their most expensive prescriptions. Three pharmacists mentioned that they dealt with coordination of benefits problems between the State's Pharmacy Assistance Program (SPAP) and the drug card program in Phase II.

A few pharmacists declared that as they became more familiar with the specifics of the drug card program, they were better able to help Medicare beneficiaries. These pharmacists attributed their ability to help beneficiaries more effectively to a few factors: narrowing down or selecting the drug discount cards that were best for their customers, resolving coordination of benefits issues with SPAPs, and receiving advice from pharmacy trade associations on which cards to promote.

Overall Experience, Impacts, and Lessons Learned

Overall Experience

Similar to Phase I, in Phase II, pharmacists found that beneficiaries did not understand the drug card program and felt confused by it. Pharmacists noted that beneficiaries found the large number of cards overwhelming.[15] An additional challenge highlighted in Phase II was **beneficiaries expected significant savings from the drug cards and were disappointed when those savings were not realized.** This created a dilemma for pharmacists on how to explain these lower-than-expected savings to beneficiaries. In these situations, respondents declared that they needed to have concise information tools to share with beneficiaries that help explain the program details.

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[13] One pharmacy changed ownership and therefore the new pharmacy owner participated in the Phase II interview.

[14] See Section 9 Results Community Case Studies for details on the site visit communities.

[15] While the pharmacists interviewed for this report believed that beneficiaries were overwhelmed by the large number of choices, Abt's evaluation of the Medicare drug card's beneficiary impacts found that beneficiaries rarely considered more than one card and the majority had not sought help in their decisions.

Pharmacists in the focus groups were asked about the benefits of the drug card program. The common response was that the TA benefit offered real savings to beneficiaries; for those that had a drug card without the TA, their benefit was "better than nothing."

Impacts

Independent pharmacists and focus group respondents were asked about the program's impact on their businesses. The majority of the independent pharmacists interviewed and pharmacists in the focus groups reported that the program had minimal or no impact on their pharmacies, mostly due to low enrollment among their customer base. A few pharmacists noted that their gross profit margins decreased because of the program, while others stated that their margins would have decreased if more of their customers enrolled in a drug card.

From pharmacists' point of view, the program's most important impact on them was the **significant time impact** of the program on their businesses. They believed that they had shouldered the responsibility of educating beneficiaries about the program. Additionally, when price questions arose, beneficiaries expected pharmacists to call the card sponsor to investigate the discount. Pharmacists stressed that they did not receive any compensation for this additional time spent counseling beneficiaries about the program and that this lack of compensation created a strain on their staff and pharmacy resources. Helping beneficiaries select a drug card was particularly time consuming and challenging because the conversation had to be shaped around the individual drug needs of each particular beneficiary.

Experience Checking the TA Balance

Focus group respondents were unable to receive a beneficiary's TA balance when processing a drug card at the point of sale. Pharmacists often needed to call the card sponsor to determine the TA balance for a beneficiary. They pointed out that some **beneficiaries did not understand that the $600 TA would eventually run out and that beneficiaries were very unhappy when the TA was exhausted.** Pharmacists did not welcome the responsibility of informing beneficiaries when their TA balance was depleted.

Coordination of Benefits with Drug Cards and other Discount Cards or Insurance

When focus groups respondents were asked about their experiences coordinating customers' benefits, pharmacists consistently stressed that **beneficiaries expected them to process multiple drug cards (Medicare and non-Medicare) through their systems to check which one would give the best price on a specific prescription.** These activities were time and labor intensive. Additionally, each time a pharmacist ran any benefit card through the system, they would be charged a transaction fee and pharmacies were not guaranteed that the beneficiary would purchase the drug. Pharmacists had difficulties associated with the evolving nature of the formularies during the implementation of the drug card program.

Lessons Learned

Several pharmacists reported no lessons learned regarding low-income beneficiaries. Pharmacists did have two observations about working with this population. First, Medicare beneficiaries were confused about the $600 transitional assistance and did not understand how it worked. Second, many beneficiaries were unsure if they would qualify for the TA and often asked pharmacists for help in trying to determine if they would qualify.

Based on their experiences with the drug card program, pharmacists were concerned that they would lack the necessary education and materials to successfully answer beneficiaries' questions about Part D.

Experience with CMS

In the in-depth interviews, the majority of independent pharmacists reported no direct experience working with CMS for the drug card program. With some pharmacists, the only contact with CMS was their referring beneficiaries to the CMS website or toll-free hotline.

Role of Community Pharmacist in Helping Beneficiaries with Drug Benefits and Costs

While pharmacists thought that their ideal role was focusing on drug therapies with customers, they realized that part of their job was to help people manage their drug costs. Although pharmacists acknowledged that they are a "sounding board" and "comfort zone" for many Medicare beneficiaries, respondents stated that it was extremely hard to provide the correct guidance when they did not have the time and resources to adequately perform these functions. A majority of pharmacists in both the interviews and focus groups resented the benefits/counselor role required of them for the drug card program and the upcoming Part D program, especially due to not being reimbursed for these activities. **Pharmacists thought these programs required them to spend the majority of their time answering beneficiaries' questions about drug costs and savings, rather than helping beneficiaries with more clinical drug therapy concerns.** Despite the fact that the pharmacists were not satisfied with the program conditions around compensation, **many pharmacists were inclined to advocate for their customers and to help beneficiaries by providing accurate and useful information about the upcoming Part D program.**

Experience Reaching the Target Population

When independent pharmacists were interviewed about their efforts to raise awareness or educate beneficiaries about the drug card program, over half of the respondents reported handing out applications to beneficiaries for one or a few specific drug cards accepted at their pharmacy. The remaining pharmacists did not make any direct efforts to promote the drug card program and only answered beneficiaries' basic questions about the program.

Pharmacists in the focus groups discussed how they helped beneficiaries understand the drug card program. The varied responses included providing information about the program in the pharmacy, handing out applications or information booklets, setting up information tables or putting up signs, discussing the $600 TA option with beneficiaries, and referring beneficiaries to the CMS website or toll-free hotline.

Pharmacists believed the following techniques were useful in the drug card program and would be effective in reaching beneficiaries on the subject of drug benefits:

- Placing advertisements in the newspaper and on TV
- Conducting outreach to churches and senior centers
- Providing enrollment assistance to help low-income beneficiaries
- Referring beneficiaries to 1-800-MEDICARE

In the focus groups, the Project Team asked pharmacists to discuss the types of questions about the drug card program asked of them by beneficiaries. The most common question raised was, **"What are my drugs going to cost with the drug card?"** Beneficiaries also asked pharmacists to help decide, "Which drug card is best for me?" and "Will I qualify for the TA?"

Over half of the independent pharmacists interviewed and half of the pharmacy focus group participants thought that the best way to reach beneficiaries was through face-to-face communication between the pharmacist and beneficiary. **Pharmacists requested clear, concise information tools for Part D detailing formulary information and income eligibility requirements for Extra Help.**

Experience with Enrollment and Beneficiary Choice

Pharmacists in the focus groups discussed factors that affected beneficiaries' decision to enroll in a drug card. The most referenced factor was the costs and savings for beneficiaries' specific drugs. Pharmacists also thought that beneficiaries' decision about whether to enroll in a drug card or not was influenced by:

- The drug cards offered/accepted in their pharmacy
- The cost/application fee for a drug card
- The beneficiary qualifying for TA

Independent pharmacists interviewed discussed their efforts that supported beneficiary choice in selecting a drug card. A few pharmacists actively assisted customers with choosing a drug card, while the majority of respondents did not help customers decide among the drug card options. Pharmacists helping beneficiaries select a drug card often gave out application packets for one specific card or a few cards accepted at the respondent's pharmacy.

Information Needs, Sources, and Gaps[16]

Drug Card Program, Information for Own Decision Making

When pharmacists were asked what types of information they needed for their own decision-making about the drug card program or gaps in information, **the most frequent request was the need for clear, straightforward, accessible information about each drug card.** Pharmacists wanted to understand formulary details and costs of drugs for each drug card. Additionally, they wanted to hand out this information to their customers. Many pharmacists reported never seeing information on all of the drug cards available in their state and having only seen information on a few select cards during the duration of the drug card program. Some independent pharmacists also requested clear information about how the pharmacy would be reimbursed by each drug card.

The source for drug card information mentioned most by pharmacists was the card sponsors. Chain pharmacists received information from their chain headquarters. Other pharmacists received information from trade journals. Only a few of pharmacists mentioned receiving information about the program from CMS materials.

[16] Chain pharmacists in the in-depth interviews were not asked about information needs, sources, and gaps, rather chain pharmacy executives responded to these questions.

Part D, Information for Own Decision Making

Pharmacists had similar information needs for Part D as they had for the drug card program. Respondents cited the need for formulary information about the PDPs, including the details of each plan, including deductibles, premiums, co pays, and the donut hole. Pharmacists desired clear, concise information to share with beneficiaries about the individual plans, income eligibility for the Extra Help, and timelines of important dates, such as when enrollment begins and when the penalty for not-enrolling will occur for certain beneficiaries.

Predominately, pharmacists received information about Part D from pharmacy organizations and PDPs. Pharmacists also received information from conferences and seminars hosted by pharmacy organizations, which many described as helpful. Chain pharmacists in the focus groups received information about Part D from their chain headquarters. Consistent with information on the drug card program, only a few received information about Part D from CMS.

Plans for Part D

During the focus groups, pharmacists were asked to elaborate on any specific plans that they had in place for Part D. Their answers included:

- Providing Part D information by setting up an information table, handing out information, playing an informational Part D video, or referring beneficiaries to the CMS website
- Designating a Part D specialist within the pharmacy
- Inviting PDP sponsors to visit the pharmacy to answer beneficiaries' questions
- Holding individual appointments with beneficiaries
- Handing out information regarding Extra Help to all customers
- Attending training sessions and understanding the specifics of the program
- Telling beneficiaries to check with a pharmacist before signing up with a PDP to ensure that their drugs are covered on the plan's formulary
- Deciding which PDPs to accept at the pharmacy based on pharmacy reimbursement

Anticipated Challenges during the Transition from MDDC to Part D

A rich topic of the focus group conversation centered around the anticipated challenges during the transition from the drug card program to Part D. Pharmacists were concerned that during the transition, beneficiaries will expect pharmacists to have all of the answers and information that they needed. At the time of the Phase II interviews, pharmacists did not have necessary information to best serve their customers and believed they would appear ignorant about the program. Pharmacists expected beneficiaries to take out their frustration and confusion on pharmacists and anticipated that beneficiaries will blame them if they are not satisfied with the savings from Part D. Some pharmacists were aware that the government is restricting pharmacists from being able to help beneficiaries select a PDP. All of these reasons caused pharmacists to be more hesitant to counsel beneficiaries. An unrelated challenge and anticipated problem was the concern over mail order. Pharmacists were concerned that PDPs may force beneficiaries into mail order, which would be detrimental to community pharmacies.[17]

[17] While pharmacists were very concerned about beneficiaries' increasing use of mail order, Abt's evaluation of the Medicare drug card's beneficiary impacts suggested that most beneficiaries did not use mail order when they used their drug cards.

Early Experience with Part D

Pharmacists reflected on their experiences helping beneficiaries understand Part D. At times, many pharmacists felt that they did not have the necessary information, such as specific PDP formularies or plan information, to help beneficiaries make choices about the program. Some pharmacists were able to answer only broad questions about Part D; others, who did not have the necessary information and did not feel prepared, could not provide any information to beneficiaries. Respondents reported that some beneficiaries were confused and frustrated about the Part D program. **Due to pharmacists' perceived lack of suitable information, some created and disseminated their own brochures explaining Part D.**

A dominant theme from the Phase II interviews and focus groups, which took place in Fall 2005, was that pharmacists reported that they were already being bombarded with questions from Medicare beneficiaries about Part D. The respondents reported the question most often asked by beneficiaries was, "Which PDP should I sign up for?" While some pharmacists would like to help beneficiaries choose a PDP and beneficiaries are looking to their pharmacists for help in this process, CMS guidelines do not allow pharmacists to help beneficiaries select a specific PDP. Pharmacists were also asked: "How much will it cost me?" and "What drugs will be covered?" Pharmacists struggled with these questions because they did not have the information needed to answer them and were not allowed to assist beneficiaries.[18] In general, pharmacists did not feel prepared to knowledgeably answer questions and guide beneficiaries about Part D.

Discussion

In Phase I of the study, similar to chain pharmacy executives, pharmacists reported participating in the drug card program to meet the needs of their elderly customers. **At that time and again in Phase II, pharmacists reported little or no communication with CMS.** In Phase II of the study, pharmacists reported that many beneficiaries with the TA benefited from the program. Pharmacists saw lower than expected enrollment in the program among their customers due to a variety of reasons (previously discussed). Consistent with other stakeholders, pharmacists identified the need for informational materials that are clear, concise, and in terminology that beneficiaries to understand. These materials were critical to informing beneficiaries of their options and details of the drug card program and would be essential to the success of Part D.

[18] At the time of the interviews and focus groups, formulary and specific drug prices were not made public yet.

5. Results: Interviews with Manufacturers

The following chapter discusses findings from interviews with manufacturers of prescription drugs.

Description of Respondents

In Phase I of this study, 16 manufacturers of prescription drugs discussed their experiences with the drug card program. In Phase II, nine of the Phase I respondents participated in the follow-up discussions.

All of the respondents were at the Director or Vice President levels and were responsible for both prescription drug card implementation and Part D planning. The respondents' role had not changed since Phase I.

Changes in Approach to Drug Card During 2005

All respondents reported **no or minimal changes in their approaches** to the drug card program. More than half of the respondents who reported minimal changes mentioned a shift of focus to Part D.

Overall Experience, Impacts, and Lessons Learned

Overall Experience and Impacts
Manufacturers' comments on program impacts repeated themes described in Phase I. Every organization reported a modest or minimal impact from the drug card program. A majority reported a moderate financial drain due to the rebates. Several mentioned a drain on staff resources at the program's outset, largely due to contracting and systems work. **In every case of reported impacts, the demands on staff had dropped off dramatically in the program's second year.**

In addition, repeating another strong theme from Phase I, three manufacturers mentioned continuing difficulties with certain sponsors, including sponsors lacking transparency in their fees, sponsors not adjudicating claims properly, as well as the contracting complexities creating hassles in sponsor-manufacturer relationships.

Lessons Learned
Almost half of respondents stated that the drug card program had offered a helpful learning experience for Part D, which was consistent with answers provided in Phase I. Most of the respondents claimed that they did not learn much about the low income and transitional assistance populations from the drug card program. These respondents felt that they already had a good understanding of the low-income populations and knew that the populations were hard to reach and harder to enroll.

Some respondents described specific lessons related to Part D. For example, some respondents believed that the systems implementation and contracting work for Part D was successful due to the drug card program "paving the way;" others believed their better relationship with CMS represented mutual "lessons learned." Three other respondents stated that the drug card program and surrounding activities were not relevant to Part D; therefore, these respondents believe that there were not any

lessons that could be carried forward. Three said that, as a result of the drug card experience, they recognized that they, and CMS, must develop better and simpler communications for Part D. Three mentioned their frustrations with enrolling low-income beneficiaries and expected similar difficulties under Part D.

Experience with CMS

In Phase I, the manufacturing sector felt that it was not able to provide input into the design and rollout of the drug card program and that CMS was not particularly responsive to the manufacturers' concerns. A year later**, the majority of organizations were favorably impressed by CMS's growth and evolution between the time of the passage of the program launch and the time of the second interview. They noted improved communications, more reasonable timelines, a better-informed staff, a greater willingness to listen, and the fact that more of their feedback was incorporated into policy.** Repeating a theme from Phase I, manufacturers also noted the hard work and dedication of CMS' staff.

Even though most respondents were complimentary of CMS, two respondents from large manufacturers believed that due to the lobbying power and influence of PBMs, the program design of the drug card program favored PBMs relative to other stakeholders; some manufacturers had also been frustrated with PBMs in Phase I.

Seven respondents commented either that they had little interaction with CMS regarding the drug card program (due to CMS shifting its focus to Part D) or that they could not distinguish their interactions with CMS as being specific to the drug card program and not Part D.

In Phase I, respondents felt the accuracy and timeliness of information from CMS was poor and that the program suffered from not enough planning or preparation. In Phase II, three manufacturers **complimented CMS on the timeliness and accuracy of Part D** materials in comparison to the drug card program materials, while two complained that problems in accuracy and timeliness persist.

Information Needs, Sources, and Gaps

Drug Card Program, Information for Own Decision Making

Most of the respondents cited sponsor pricing and formularies as their primary need for information on the drug card program. Nearly half cited the need for beneficiary information: e.g. the numbers enrolling in the drug card program and in individual cards, the numbers actively participating, etc. Four mentioned a desire for better information on the extent to which sponsors translated manufacturer rebates into lower prices for beneficiaries. Three respondents said there were no significant gaps in information. Manufacturers' sources of information for the drug card program were CMS, the plan sponsors, internal analysis, vendor reports, and databases.

Part D, Information for Own Decision Making

At the time of the Phase II interviews, respondents desired a variety of information materials about Part D, including approved plans by region, the PDP formularies, the specific benefit designs for each approved PDP, data on drug utilization for the Medicare population, and an understanding on what utilization techniques the PDPs were and were not able to use.[19] Respondents used a variety of

[19] CMS did publish some of this information shortly after the completion of some interviews.

sources for Part D information, such as CMS (for the approved list of plans and the regulations for PDPs), PDPs (for formularies and benefit designs), and vendors (for data on drug utilization).

Plans for Part D

At the time of the Phase II interviews, every respondent organization was in the process of contracting with PDPs or had already completed their contract negotiations for the Part D program. Seven respondents were conducting Part D outreach efforts. Six respondents had developed educational materials for their in-house staff, and four had created new marketing and pricing strategies to position themselves well under Part D (details were not discussed). Several organizations had created special staff positions and more robust internal teams in preparation for Part D. None of the manufacturers had any plans to integrate their PAP programs with Part D. Most said they would await any rulings from the Office of the Inspector General (OIG), but their current understanding was that such partnerships were not legal.

Discussion

In Phase I, manufacturers stated that they participated in the drug card program in pursuit of three main objectives: to help the needy; to support the government's program and the private-public partnership; and to learn critical lessons for Part D. There was a genuine sense that the program was aimed at improving the lives of the public and could be an example of the benefits that could result from close collaboration between the public and private sectors.

In the Phase I interviews, many manufacturers went out of their way to compliment CMS on doing the best job they could with an extremely aggressive timeline and felt that a satisfactory program was better than not having a program at all. Most expressed hope that CMS would learn from its own experiences and apply the lessons to Part D.

In Phase II, manufacturers did not refer to the objective of participation of helping the needy at length. They did note their ongoing support for the concept of a private-public partnership. Respondents were split over whether the drug card program had provided an opportunity to prepare for Part D or whether this experience was not particularly relevant to Part D.

In Phase II of our research, nearly every manufacturer **favorably commented on how different the process of Part D planning had been than the process leading up to the drug card and how much better their relationship with CMS had become.** In Phase II, respondents **complimented CMS on providing more advanced notice of changes and policies, better information, a far improved willingness to listen and compromise, greater involvement of the manufacturers, and the establishment of open lines of communication.**

6. Results: Interviews with State Pharmacy Assistance Programs

Introduction

In Phase I, the Project Team synthesized secondary data about State Pharmacy Assistance Programs (SPAPs) and their experiences with the drug card program. Kimberley Fox, then of Rutgers University, was the author of a number of the studies we examined. In 2004, Fox conducted in-depth interviews with SPAP officials; this was just as the stakeholders' study was getting underway. While extremely interested in hearing the SPAPs' perspectives in Phase I, CMS believed that the burden of another set of interviews was too much to request in relation to the amount of new information that would be gained from again interviewing the SPAPs.

Building on Fox's work conducted during Phase I, the Project Team in Phase II interviewed SPAP directors to document their experiences with a mature drug card program and to learn about their plans for Medicare Part D. For perspective, Kimberley Fox served as a consultant to the Project Team in Phase II. This chapter is based on analysis of interviews with directors and managers of 14 State Pharmacy Assistance Programs (SPAPs). Two of these interviews were conducted in-person as part of the community case studies; twelve were conducted by telephone.

Background on SPAPs and Description of Respondents

State Pharmacy Assistance Programs are State-sponsored programs designed to lower the cost of prescription drugs for seniors and persons with disabilities. These programs are funded primarily with State dollars, though some receive additional funding from other sources. In November 2005, 32 States had pharmacy assistance programs in operation and 21 received transitional grant awards. We invited 18 of those SPAPs to participate in the interviews. We excluded three, which either offered end benefits to individuals with certain medical conditions or only offered benefits through 1115 waivers rendering their members ineligible for transitional assistance.

State Pharmacy Assistance Programs provide either a direct pharmacy benefit or a pharmacy discount to enrollees. In direct benefit programs, the State pays most of the costs of prescriptions while enrollees are responsible for co-payments sometimes with other forms of cost sharing, such as premiums and deductibles. Discount programs provide participants with lower drug prices by using a drug card or through a purchasing pool. Nationwide, as of late 2004, 18 SPAPs provided direct benefits, nine provided discounts, and five provided both. Thirteen study respondents represented States that provided direct benefits and one provided both direct benefits and discounts.

Eligibility requirements for SPAPs vary widely by State. Nationally, income requirements range from 100 percent of the Federal poverty level (FPL) to 500 percent FPL. In 2004, all State Pharmacy Assistance Programs covered individuals aged 65 and older while half covered individuals with disabilities under age 65. For SPAPs participating in our study, eligibility requirements range from incomes of 100 percent FPL to 500 percent FPL. All participating SPAPs covered persons aged 65 and older and six covered individuals with disabilities under age 65.

All but one respondent described his role as managing or administering the SPAP, including directing policy decisions and overseeing day-to-day operations of the program. Four respondents reported

that their organizations contracted with pharmacy benefit managers and financial intermediaries that were responsible for processing applications and billing. One respondent reported that he was responsible for processing applications.

Changes in Approach to Drug Card During 2005

All respondents reported **no changes in their approach** to the drug card program since January 2005. Two SPAPs, however, told us that they began auto-enrollment in late 2004. One **SPAP program that had State funding for a statutorily mandated timeframe was able to extend its operations, to increase income eligibility limit, to expand its formulary, and to eliminate other eligibility require**ments for a few months as a result of the savings the SPAP incurred by coordinating with a Medicare-approved drug card.

Overall Experience, Impacts, and Lessons Learned

Overall Experience and Impacts

In contrast to some other stakeholder groups, SPAPs felt little administrative burden as a result of the Medicare-approved drug card and TA program. In fact, SPAPs that coordinated with the drug card program reported experiencing financial savings, which allowed some to increase benefits offered by their programs.

Nine respondents reported **no direct impacts** on the staff or workloads as a result of the Medicare drug card and TA program. Three respondents explained that the lack of impact was a result of their use of auto-enrollment, thereby creating a seamless transition from the viewpoint of beneficiaries. Two others explained that they had decided not to pursue coordination of benefits, thereby, avoiding an administrative burden for their organizations. Four respondents reported direct impacts on their workloads, such as an increase in phone calls and walk-in visits from their members or an increase in calls from the SPAP's pharmacy benefits manager.

Three respondents reported that their programs experienced financial savings as a result of the drug card and TA program. Two mentioned that their programs were able to offer greater benefits as a result of the drug card program.

Lessons Learned

When asked what they learned from their experiences with the drug card program, few respondents identified lessons on communicating with beneficiaries and coordination of benefits. Consistent with other stakeholders, two respondents mentioned that beneficiaries need one-on-one consultation and another commented that beneficiaries need time to absorb and comprehend the information. Two other respondents commented that the capacity to auto-enroll in a single drug card was important because of the challenges of explaining so many drug card options.

Five respondents reported applying the lessons learned in reaching the target population (discussed in detail below) to their Part D preparations. Their activities included:

- Staffing and marketing a Part D education and enrollment bus
- Posting information on local TV channels
- Funding SHIP hotlines to extend coverage to Saturday
- Sending out fliers to membership

Experience with CMS

SPAPs had varied experiences working with CMS. Most were generally sympathetic to the time constraints placed on the Agency. Two respondents were pleased with the evolved relationship with CMS and were encouraged by CMS' collaborative effort. Two respondents commented on the **improvement of the flow and content of information over Phase II**. Five respondents mentioned that **their programs had difficulty with CMS around gaining access to the enrollment data** and three respondents reported problems with enrollment data and matching CMS' enrollment data to the SPAPs' membership lists.

Experience Reaching the Target Population

Nearly all respondents reported doing outreach to their SPAP members to educate them about the drug card program. Outreach approaches ranged from a simple letter or flier to SPAP members to a multi-pronged strategy involving outreach by multiple government agencies. Of the SPAPs reporting outreach activities, all but two used more than one mode of communication with beneficiaries. Types of outreach mentioned by respondents included:

- Giving presentations at church events, senior centers, the State fair, and other community events
- Sending bulletins to pharmacists for distribution to beneficiaries
- Convening town-hall meetings
- Issuing news releases

Some respondents stated that their outreach activities focused on the SPAP membership where the majority of members were eligible for the transition assistance rather than a broader senior population. One SPAP relied on the pharmacists to answer beneficiaries' questions and to help them find the best plans based on their needs. In this case, the State reimbursed pharmacists for providing counseling services to the SPAP client, possibly creating the impetus for pharmacists to counsel beneficiaries.

When asked to describe lessons learned about communicating with beneficiaries, four respondents mentioned that one-on-one contact either in person or by telephone was the best way to communicate effectively with this population. Additionally, some respondents raised the **importance of connecting and partnering with a trusted member of the community to provide information to beneficiaries**.

Experience with Enrollment and Beneficiary Choice

SPAPs used a variety of mechanisms to promote enrollment in the drug card program. SPAPs had the option of working with a preferred drug card or allowing their members to enroll in one of several drug cards. Half of the SPAPs selected a preferred drug card for their members with the provision that members could opt-out of that drug card program and select another. **Those that selected a preferred plan were generally pleased with the enrollment process.**

Experience Reaching Providers and Beneficiary Organizations

SPAPs used a variety of methods to inform and educate providers and beneficiary organizations about the drug card program. Most notably, SPAPs utilized existing relationships with State Health Insurance Programs (SHIPs), workgroups, coalitions, and other partners to conduct local and statewide trainings. In most States, SPAPs collaborated with SHIPs to conduct provider trainings and educational sessions, to assist community agencies and AARP branches in organizing their own train-the-trainer meetings, and to educate the pharmacy sector. For example, in one State, the SPAP and Medicare coalition conducted ten statewide trainings; additionally, this coalition worked with a School of Pharmacy in its State to train hundreds of pharmacists on drug card benefit issues

Experience with State / Federal Partnerships

Experience with enrollment varied considerably from one SPAP to another. Respondents used different approaches to enroll their members in the drug card program. Some State programs auto-enrolled their members in the drug card program, while others allowed members to enroll voluntarily. **States that conducted auto-enrollment generally had favorable experiences with the drug card program.** Two SPAPs mentioned that auto-enrollment and the TA greatly increased enrollment in the State's program. Two States mentioned challenges in receiving the necessary Medicare data from CMS to allow auto-enrollment.

States that successfully coordinated benefits experienced substantial savings from the TA program. Five respondents noted that their States required the $600 credit to be used before the SPAP program would pay for prescriptions. Of these, four respondents mentioned that they had no difficulty coordinating benefits for their members. In at least three cases, the fiscal entity processing claims for the preferred drug card was an organization that the SPAP had used previously.

Experience with State / Sponsor Partnerships

Half of the respondents chose to work with one preferred drug card. Some of these respondents mentioned that the drug card with whom they worked was chosen through a review of proposals submitted by the sponsors. In selecting a drug card, the SPAPs considered the cost of the drugs that most of their members used, the pharmacy networks, and the ability of the sponsor to match the SPAP's current price on the most frequently used drugs.

Information Needs, Sources, and Gaps

Drug Card Program, Information for Own Decision Making
Four respondents addressed the question of information needs. Three respondents commented that they received adequate and appropriate information from CMS on the drug card. The majority of information was accessed through CMS, with some information from other SPAPs, the Kaiser Family Foundation, drug card programs, and the Medicare Modernization Act. Respondents identified few gaps in the information related to the drug card program. Some discussed gaps included detailed information about participating sponsors and drug cards earlier than they received the information and the lack of enrollment data from CMS.

Part D, Information for Own Decision Making
As the implementation date of Part D approached (at the time of Phase II), two respondents mentioned that they were interested in learning the details of the drug plan benefits and formularies.

CMS continued to be a source of information for the SPAPs. Three SPAPs wished to connect with the Part D plans to get operational information from them. Two respondents discussed the importance of determining the number of SPAP members who qualified for Extra Help.

Plans for Part D

SPAPs have three options on Medicare Part D: redesign their programs to coordinate with Medicare Part D; retain their original program design after Part D is implemented; or discontinue operations. In Phase II, ten of our study's respondents reported that they planned to redesign their programs to provide wrap-around coverage for their members enrolled in Medicare Part D. Three respondents stated that their programs would end when Part D begins; one indicated that the State program would end unless State legislation is passed to allow wrap-around provisions.

In recent months, SPAPs made critical decisions regarding their future roles in providing pharmacy assistance to low-income persons. At the time Fox conducted the studies reviewed in Phase I, SPAPs were considering whether and how they might operate after the implementation of Medicare Part D. At the time of the Phase II interviews, one month prior to the start of the Part D benefit, all but one respondent decided how to proceed with Part D. Eight respondents planned to redesign their benefit plans to wrap-around the Part D benefit. While the designs will vary by State, the respondents programs planned to pay some combination of deductibles, premiums, and out-of-pocket expenses incurred during Medicare's period of non-coverage, the so-called "donut hole." As SPAPs were not allowed to select preferred plans for their members under Part D, they needed to coordinate benefits with multiple Part D sponsors. Two respondents mentioned that they had applied for the "intelligent random assignment" so that the SPAP could select the best plan for each of its members. Irrespective of their program's design, the short time frame that SPAPs had to work with the Part D plans prior to the program's launch was a source of concern for some respondents.

Discussion

The SPAPs' thinking about the drug card program has evolved since the start of the program. Our Phase I secondary source review revealed that SPAPs faced challenges with the drug card program with beneficiary outreach, education and coordination of benefits. **SPAPs interviewed in Phase II reported that they were able to address some of the Phase I issues, while other challenges remained.** The complexity of the drug card program made beneficiary education challenging for SPAPs. Some SPAPs devised strategies to provide information using a layered approach, so that they could reach large numbers of enrollees by mail, while providing opportunities for individuals to ask questions in follow-up phone calls and/or in-person counseling. The Phase II interviews revealed different SPAP experiences than those reported by Fox in 2004. **First, Phase II respondents did not report lacking sufficient information to educate SPAP enrollees about the drug card program. Second, Phase II respondents reported that issues with coordination of benefits that emerged early in the drug card program were solved over time as CMS provided data and SPAPs became more adept at using the information.**

7. Results: Interviews with Organizations Serving Beneficiaries

This chapter describes findings from interviews with service organizations that work on behalf of beneficiaries. The first section of the chapter discusses interviews with State Health Insurance Programs (SHIPs) and the second section discusses interviews with other information intermediaries.

7.1. State Health Insurance Plans

Description of Respondents

Respondents from eleven of the twenty-two State Health Insurance Assistance Programs (SHIPs) from Phase I were interviewed. All but one respondent was the program director of State Health Insurance Assistance Programs (SHIPs).

SHIPs are administered in either the State's Health Insurance Agencies or in the State's Departments of Aging. Phase II respondents included five SHIPs located in State Departments of Aging (14 in Phase I) and six SHIPS in State Health Insurance Agencies (eight in Phase I). Respondents did not report any changes made to the organization with regard to its mission, products, or clientele, etc. SHIPs continued to provide information and counseling, as well as outreach services, to Medicare beneficiaries and their partners, families, and caregivers.

While the type of work reported by respondents had not changed, four respondents reported an increase in their workload in Phase II. As SHIP Program Directors, respondents provided general oversight of the SHIP program, conducted volunteer trainings, and developed training and beneficiary educational materials.

Changes in Approach to Drug Card During 2005

Most respondents commented that **no changes were made in their organizations' approaches** to the drug card during 2005. Respondents noted that the programs received less attention over time. Some respondents explained that their drug card education and outreach efforts decreased substantially since the beginning of 2005; in fact, respondents had transitioned to focusing on preparation for Part D. In contrast to Part D, the temporality of the drug card program decreased interest of the drug card program, whereas the penalties associated with enrolling in Part D created increased interest and anxiety among beneficiaries, providers, and senior advocates.

Overall Experience, Impacts, and Lessons Learned

Overall Experience and Impacts

Six respondents reported a **significant impact** on their organization due to CMS' promotion of the role of SHIPs as an information resource. In response to the increased visibility of using SHIPs as a resource, respondents increased staffing and outreach to meet the increased demands for educating beneficiaries and partnering with more organizations to assist beneficiaries. Three respondents specifically described their staff as overwhelmed and burdened by the increased information requests. These respondents also remarked that funding and staff resources were inadequate in the face of the demands. In contrast, three respondents reported little to no impact from the drug card. For these

SHIPs, the drug card program was generally a "non-event" because of the strong State Pharmacy Assistance Programs offering better benefits.

Lessons Learned

Five respondents commented that the low-income populations are the hardest population to reach and some respondents stated the difficulty associated with encouraging the population to access information. Reiterating Phase I themes, respondents thought messages to the low-income population must be carefully crafted, with simple messages encouraging the reader to act.

The differing nature of the SHIPs' experiences created varied lessons learned. Three respondents remarked on **their new awareness of the tremendous need for prescription coverage and the dissatisfaction with the drug card and its benefits**. Echoing a Phase I theme, some respondents spoke of the importance of partnerships; they explained how partners were especially critical to reach low-income beneficiaries because they often serve as gatekeepers to beneficiaries. Two respondents learned that, due to the importance placed on the Internet, computer accessibility was critical, to successful enrollment. **In Phase II, some respondents took measures to ensure computer access at all SHIP outreach sites and also trained volunteers to use the Internet to facilitate their mastery of the Plan Finder tool.**

Experience with CMS

Lessons about working with CMS also varied among respondents. Similar to Phase I, most respondents generally spoke positively of their experience in working with CMS. Among such responses, respondents commended CMS on their willingness to provide technical assistance, their open communication and responsiveness, and their helpful publications. Respondents continued to credit CMS for their efforts in trying hard to make the drug card experience successful and acknowledged that CMS is often constrained by its bureaucracy, which makes it difficult for CMS to meet their own deadlines in distributing information to the SHIPs. **In Phase II, three respondents also noted that CMS had unrealistic expectations on what the SHIPs could provide given limited resources.**

Typically, those respondents that had more positive experiences explained that they would continue to be patient and work collaboratively with CMS by being more proactive with them (e.g. inviting them to their presentations). Other respondents explained that they have no expectations of assistance from CMS and will try to be more independent in developing their own resources.

Experience Reaching the Target Population

In Phase II, almost all respondents **stressed the use of partnerships and/or use of various forms of media as more efficient modes of reaching target populations**, especially low-income populations. Six respondents reported expanding their partnerships in Phase II to **include community-based organizations that work directly with beneficiaries.** Other respondents remarked that they have increased their efforts to target the caregivers of seniors (e.g. case workers, outreach workers, family or friends).

Several respondents learned through the Phase II implementation that unless **the messages were short, direct, and clear about the necessary action steps, their existing print materials and mailings did little to elicit action from beneficiaries, especially among low-income beneficiaries.**

In Phase II, many respondents **enhanced their efforts through the use of different media methods**, namely television (e.g. public service announcements or call-in talk shows), radio, and press releases to reach the target population.

Experience with Enrollment and Beneficiary Choice

Efforts to support beneficiaries in enrolling and choosing a drug card were steady over Phase II. Throughout the implementation of the program, respondents continued to provide one-on-one counseling, some respondents used the Plan Finder tool to assist beneficiaries in making their selection. Two respondents with State Pharmacy Assistance Programs (SPAPs) explained how SHIPs and SPAPs **engaged in partnerships** in Phase II to co-facilitate trainings and provide group trainings to their staff to have all individuals assisting beneficiaries draw on the same information.

Experience Reaching Providers and Beneficiary Organizations

Many respondents pointed to their extensive network and partnerships as successful elements of their trainings for providers and beneficiary organizations, including collaborations with State bureaus, local agencies, and traditional and non-traditional organizations. SHIPs designed and conducted provider trainings for partners, providers, State agency staff, case managers, pharmacists, internal SHIP counselors, and other beneficiary organizations. Additionally, SHIPs provided train-the-trainer meetings for AAAs, State agencies, and local beneficiary organizations. Most respondents believed that the coordination between State and local efforts and agencies was and will continue to be essential to ensure that a consistent message is conveyed to providers.

Information Needs, Sources, and Gaps

Drug Card Program, Information for Educating and Assisting Beneficiaries
CMS was the primary source of information for the drug card program cited by all respondents. Many respondents described the online drug card finder tool as providing some of the necessary information for counselors to assist beneficiaries in their decision-making. Publications from CMS were typically cited as useful forms of information needed to help educate beneficiaries. However, three respondents noted the most valuable publications - those that were most concisely written, relevant and visually appealing - were not readily accessible. Some respondents believed that PDAPs and/or the drug card finder were invaluable tools to gather appropriate information for beneficiaries to make choices. A few respondents suggested that they needed, but never had access to the following: summary of additional benefits, pharmacists' networks (e.g. which pharmacies accepted which drug cards), and the average discount on brand-name drugs versus generic drugs.

Part D, Information for Educating and Assisting Beneficiaries
The types of information for Part D differed little from those mentioned in reference to the drug card. A few respondents, did, however, stated that they needed more information on the basic plans versus enhanced plans.

Plans for Part D

Most respondents described plans for Part D that involved education and enrollment assistance to beneficiaries through increased partnerships and/or trainings. SHIP directors reported that their partnerships were a great resource for the drug card program; therefore, they stated that they would continue to rely on these partnerships in Part D, especially in reaching low-income beneficiaries. For

Part D, many respondents are forming or expanding existing partnerships or coalitions with agencies and entities that are affiliated with or have regular contact with seniors, such as local government and non-government entities such as Area Agencies on Aging, State Medicaid agency, AARP, other advocates for seniors and disabled, and other community-based organizations, such as churches and senior community centers. As these organizations have regular contact with seniors and are highly regarded and trusted among seniors, they are perfect partners for outreach and education efforts. SHIPs plan to provide trainings to these partners to prepare them in assisting seniors to make decisions about enrolling and choosing plans. Some respondents will train more SHIP volunteers for Part D. Two respondents described plans for conducting specialized trainings to volunteers or providers who work exclusively with low-income beneficiaries. Some SHIP directors fear that the SHIPs will not be adequately prepared to assist and field an anticipated flood of calls and inquiries from beneficiaries with the launching of Part D. At the time of the interviews, SHIPs were training staff and volunteers with existing information; some respondents were concerned that the Plan Finder tool was not ready to be used and that they (SHIPs) may not have much time to conduct proper trainings for their volunteers to use this valuable tool.

Discussion

In Phase I, SHIPs participated in the drug card program as part of their overall mission to assist seniors. In particular, SHIPs educated beneficiaries about the program, helped them examine their options, and assisted them in completing the application. Through Phases I and II, SHIPs had **favorable impressions of and were satisfied with their experiences with CMS**. Some SHIPS, in Phase I, were frustrated with the delays in CMS' responses and lack of coordination between CMS' regional offices and the SHIPs and other local agencies. SHIPs desired CMS to be proactive in their communications and to match their communications to the target experience. In Phase I, SHIPs suggested that CMS invest in clear and timely communications, simplify the materials, and market and promote SHIPs as a resource for seniors.

In Phase II, SHIPs believed that **CMS developed their efforts through using their Phase I experiences and stakeholder suggestions**. In particular, CMS marketed and promoted the use of SHIPs for assisting beneficiaries. Additionally, CMS' developed collaboration efforts with SHIPs to establish consistency across agencies. Some respondents were proactive in collaborating with CMS in providing trainings for various partners and providers. In Phase II, SHIPs **expanded their Phase I media campaigns to include non-mainstream and multi-media methods.** In general, Phase II provided an opportunity for SHIPs to increase their outreach efforts and to advance relationships with CMS and other stakeholders. In Phase II, **many SHIPs developed their partnerships in preparation for Part D** to include non-traditional partners (e.g. community-based organizations) and caregivers and to coordinate across stakeholder groups.

7.2. Information Intermediaries

Description of Respondents

Respondents from seven of the eight organizations interviewed in Phase I were re-interviewed in Phase II. Within these seven organizations, one respondent was new and six had been interviewed in Phase I. These organizations are located in seven different States throughout the country. Five service a mix of suburban/urban/rural areas, one is urban, and one rural.

As reported in the Phase I report, respondent organizations include a mix of service and advocacy groups, including local Area Agencies on Aging. Many organizations are associated with their State health insurance programs (SHIPs) and provide SHIP volunteers; many were involved in the Access to Benefits Coalition that specifically targeted low-income beneficiaries. Agencies provide outreach, counseling, and telephone information services.

Respondents were responsible for services focused on the Medicare eligible population, including Executive Director and managers of Medicare programs, such as directors of counseling and client services.

Changes in Approach to Drug Card During 2005

All respondents stated that there been **no changes in their approaches** during 2005. All respondents commented on beneficiaries' overall lack of interest in the drug card program and the difficulty finding beneficiaries that were eligible for Transitional Assistance (TA), despite intensive outreach campaigns. Most respondents tied the lack of interest by many who were eligible for TA to the availability of better benefits through other Federal programs, such as State Pharmacy Assistance Programs, 340B, and other assistance programs. Others commented directly that beneficiaries above the income level for TA were not interested because they could obtain similar prices easily through standard senior discounts at pharmacies or at discount stores.

In response to the lack of interest and to the decreasing amount of TA given to eligible beneficiaries (the amount of TA depends on when a beneficiary enrolls in the drug card program), most **organizations stopped intensive outreach** in Spring 2005. About that time, they began to concentrate on Part D, which these respondents saw as a positive step, i.e., preparing for a program that they expected beneficiaries to have many questions about. Most respondents noted, however, that they continued a very "low-key" campaign for the drug card program by incorporating information about the program into presentations about other subjects, newsletters, and when the topic arose during telephone discussions throughout 2005.

Overall Experience, Impacts, and Lessons Learned

Overall Experience and Impacts

About half of the respondents reported that activities to raise awareness and to assist with beneficiary decision-making on behalf of the drug card program consumed significant resources at their agencies, generally far more than they were funded to do by CMS or Access to Benefits (ABC).

Lessons Learned

All respondents had sought out low-income beneficiaries through a variety of methods, such as going to senior housing programs and advertising in non-English language newspapers, and most reported that they emphasized the TA benefit more when presenting beneficiaries in that category. A few commented that many individuals who are low-income are sensitive and sometimes ashamed about it and do not want to be identified as such, especially in a mixed group, making it difficult for respondents to know when to emphasize TA. Several respondents commented that using local partners who already have daily or regular contact with low-income individuals who are frail and "hard to reach," as was done through some ABC efforts, was often a successful strategy.

More than half of the respondents commented specifically about how **the program design (too many choices, lock-in feature, etc.) and the lack of clear value to many beneficiaries contributed to poor enrollment results even after all their outreach efforts**. Some respondents viewed CMS as having been too enthusiastic about the drug card program and "glossing over" the complicated design and amount of work involved in making choices. They worried that the **Part D benefit as sharing these features that may affect beneficiary interest.** Four respondents expressed skepticism about CMS's messages regarding the drug card program; this cynicism has carried over into Part D issues. These respondents believed that their agencies have to sift through the details to make a realistic assessment of what beneficiaries actually need to do to appropriately select a plan and how much of a benefit Part D offers beneficiaries.

Although two of the respondents have had a long history of working with Medicare, two others, prior to the drug card program, had limited experience with Medicare program rollouts. All four indicated **their agencies need to make their own assessments of Part D's value to beneficiaries, rather than accepting CMS' messages.**

All respondents were very concerned about the amount of time counseling for Part D will take and are planning accordingly. Some had already recruited and trained additional volunteers; others were making plans to address capacity issues. Also, many were anticipating the same difficulties they faced with the drug card program, i.e., that the number of choices would be overwhelming and that many beneficiaries would not be able to make a selection without close assistance.

Experience with CMS

Six respondents had worked with CMS on the drug card program. While a few respondents criticized CMS in Phase II due to their lack of interest working with information intermediaries, three respondents reported that they had excellent working relationships with individuals in the Regional Offices in their areas and one also reported having an excellent contact person in the Central Office. **They praised the work of these individuals; different respondents described different contacts as – "tireless" and "committed" in one case, and "a real partnership" and "honest" in another**. A few respondents commented on **improvements through Phase II in CMS' communications methods in the conference calls and distribution of information.**

Experience Reaching the Target Population

Most respondents noted that their intensive drug card program outreach efforts decreased in Spring 2005, although they continued to incorporate the drug card program information in other activities. More so than in Phase I, many respondents in Phase II mentioned **the importance of organizational participation in coalitions and partnerships, for planning as well as outreach**. Respondents used these lessons as critical aspects of their Part D strategies.

Experience with Enrollment and Beneficiary Choice

All respondents emphasized that helping with beneficiary choice was a time-consuming, individualized, one-to-one counseling process, no matter what was done about outreach. All used the Benefits CheckUp or Plan Finder tools for assisting with selection; Benefits CheckUp was considered easier than Plan Finder. **Several learned in Phase II that this kind of counseling was difficult to do by telephone, due to the time required and few beneficiaries having accurate information**

about their medications readily available. Two agencies **modified their approaches in Phase II and reported that they were asking beneficiaries to complete questionnaires about medications and other information prior to seeking help** so counselors could use a Plan Finder tool, then discuss the results in a follow-up phone call.

Experience Reaching Providers and Beneficiary Organizations

Information intermediary respondents had very similar experiences to the SHIPs in educating providers and beneficiary organizations. Respondents who were part of networks and coalitions provided their partners with additional and supplementary information to disseminate. Through presentations and distribution of newsletters and articles, many respondents taught providers and non-partner beneficiary organizations on the intricacies of the drug card program. Several respondents believed that CMS should have drawn pharmacists into the campaign at an early stage. Most respondents pointed to the importance of informing and educating providers well in advance of materials circulated to beneficiaries.

Experience with State / Federal Partnerships

In one State, the respondent reported that there had been a vital State campaign, including the governor, the Medicaid leader, and others, which had demonstrated commitment and leadership to the program. This had drawn media and other attention to the program and was considered a successful information delivery effort, even though final drug card enrollment was much lower than statistics suggested it should be. He noted that this leadership was continuing for the introduction of Part D and would be critical to the success of Part D.

Respondents in the four States with SPAPs reported that their SPAPs had auto-enrolled individuals into drug cards; from their recollection, the enrollment process had seemed to go well. One individual noted, however, that beneficiaries who contacted her agency were reluctant to use the Medicare drug card they received from the SPAP because they did not understand how the SPAP and the drug card program interacted.

Information Needs, Sources, and Gaps

Drug Card Program, Information for Educating and Assisting Beneficiaries

Respondents reported that they needed basic information that would help seniors or the assistance agencies with drug card selection under the drug card program. They needed information about what drug cards were available, instructional information on how to use the Internet tools, access to the drug card finder tools in a timely fashion, and information that communicated basic information to beneficiaries in simple form, such as fact sheets and checklists[20]. All respondents used CMS as a source of information, including Regional Office contacts and materials accessed through the website. Other information sources included ABC, SHIPs, the Kaiser Foundation, Families USA, and the Commonwealth Fund newsletter. In general, respondents were able to access needed materials; one respondent specifically remarked that the campaign would have been impossible without CMS's capacity to transmit information electronically, meaning the ability to download information from the CMS website for distribution and for speed of transmittal of information from CMS. However, a few

[20] Although some respondents were not aware of these resources, CMS had created a number of one-page fact sheets, check-lists, and other brief summaries of key program features and published them on its website.

respondents saw the beneficiary materials as not "consumer-friendly" or simple enough to be distributed to seniors as written by CMS.

Part D, Information for Educating and Assisting Beneficiaries

Respondents reported information needs similar to their needs related to the drug card program: consumer friendly and clear materials for beneficiaries, thorough information on the plans available in the geographic areas, the Plan Finder Tool (which was not fully available at the time of the interviews), and training materials for other professionals. CMS was named as the only or the most important source of information around Part D by the six respondents who will be involved in Part D. Three respondents were skeptical about CMS information; they stated that the materials gloss over the complicatedness of Part D. Two agencies were evaluating the value of the drug plans for themselves, rather than relying on CMS information. Three respondents saw the consumer materials as not responsive to the types of questions beneficiaries would have. On the other hand, several respondents praised their contacts in the Regional and Central Offices and reported some improvements in CMS communication to their sector.

Plans for Part D

Six organizations were intensively involved with both planning and conducting activities related to the introduction of Part D, including training of other professionals who work closely with beneficiaries in senior centers and housing, production of materials, recruitment of additional volunteers and training of volunteers, and work with media. Some had begun to deliver outreach presentations to beneficiaries. Most organizations began to focus on Part D in the Spring 2005 because of their awareness of the importance of benefit and the need to be prepared for beneficiaries' questions. One organization will not be involved in Part D other than to provide referrals because of lack of specific funding to participate.

Most respondents were expecting a surge of interest about Part D from beneficiaries; therefore, they were preparing for it. Three respondents reported that phone volume regarding Part D had increased as much as 300 percent in the week previous to our interviews (mid-October).

Discussion

In Phase I, respondents raised concerns about the drug card program design and decision-making process (too many choices, a complicated program, and a time-consuming process). Respondents believed that CMS had not raised sufficient awareness of the program among beneficiaries and saw the Internet as the wrong choice for information dissemination to beneficiaries.

Beneficiary lack of interest in the drug card program led respondents to shift emphasis away from the program early in Phase II. Agencies began to prepare for Part D early in Phase II with the Part D program. Even with the shift to Part D early in Phase II, **information intermediaries modified their drug card approaches to providing outreach and assistance to beneficiaries. Respondents diversified and improved outreach strategies and enriched their working relationships with CMS.** Some respondents saw **improvements in the CMS communication process with agencies**, but concerns continued to be raised that CMS materials directed toward beneficiaries were not simple and direct in describing the benefit and the decisions that beneficiaries had to make.

A new theme that emerged in Phase II was **wariness about Part D because it appeared to share some of the same challenges as the drug card program:** for example, a multiplicity of choices, the lock-in to a particular plan, and a time-consuming decision process. However, several agencies learned from the drug card program and were establishing new approaches to aid beneficiaries in their information needs, such as using a two-step process for choice counseling and participation in coalitions to plan outreach campaigns.

8. Results: Interviews with Expert Observers

This chapter reports on interviews with thought leaders, defined as individuals who pay very close attention to the drug card program but are not direct participants and representatives of professional associations, defined as organizations that represent provider groups. Due to the small numbers of respondents and their disparate areas of expertise, many of the views documented below are based on a very small number of respondents, often one to three. While the numbers might seem small, these views are included because the respondents typically based their views on extensive research, input from many stakeholders, and extended and intense engagement in the drug card program.

8.1. Thought Leaders

Description of Respondents

This section reports on interviews conducted with nine thought leaders. Four described their place of employment as a consulting firm, two as a think tank, one as a foundation, and one as a State Department of Elderly Affairs. One was an independent consultant, a change from her status in Phase I. With their permission, the names of these individuals and the names of their organizations appear in Appendix E. All had significant expertise in the area of Medicare policy and drug benefits. Three were presidents of their organizations.

In Phase I, these respondents were asked to identify an area of expertise among the major stakeholder groups (sponsors, pharmacies, manufacturers, States, and beneficiaries); the areas of expertise had not changed in Phase II. Eight respondents defined their area of expertise: two respondents with sponsors and manufacturers; one with pharmacies; two with manufacturers only; one with States; two with beneficiaries. One respondent resisted characterization and described himself as a policy expert.

Overall Experience, Impacts, and Lessons Learned

In Phase I, respondents reported that the program's successes were the following: the underlying philosophy of private sector provision, competition and choice; the widespread participation among sponsors, community pharmacies, and manufacturers; and the successful launch of the program on a challenging timeline. They also described at length the challenges related to rapid implementation on a short timeline, the politicization of the program, and the negative press coverage.

In Phase II when asked about the health care sector's overall experience with the drug card, experts tended to repeat themes from the Phase I interviews. Five respondents noted that the drug card was important because it brought the concept of beneficiary choice among competing drug benefit plans to the forefront of the public policy discussion. One respondent was unequivocally enthusiastic about choice; two believed it was interesting to see how beneficiaries made choices; and two suggested that, while choice might be good in theory, it did not work well for this product and this population. One respondent went so far as to say that the program was much too complicated from the beneficiary's point of view and that it would have been preferable if the government had offered the benefit directly, rather than by third parties.

Five thought leaders expressed disappointment with the level of enrollment and two stated that the program did not have much impact because of the low enrollment levels. One believed and regretted

that the "poisoned political climate" played a major role in discouraging enrollment and in tarnishing the concept of beneficiary choice. Echoing a theme heard among other stakeholder groups, many respondents stated that the drug card program offered a learning experience that would be relevant in Part D.

Experts were more specific about the nature of that learning experience than they had been in Phase I. In particular, five thought leaders emphasized the learning experience for sponsors, saying that the program allowed sponsors to learn about offering a Medicare drug benefit, including working with the Medicare population and CMS. One emphasized that the drug card program leveled the playing field between organizations that had been working in these areas for some time and organizations, notably pharmacy benefit managers (PBMs), who were new to Medicare and/or new to settings in which an individual (as opposed to an institution) was the drug benefit's customer. In the opinion of another, the drug card experience taught sponsors and manufacturers about working together to offer a Medicare drug benefit. A third highlighted that the drug card program offered sponsors a valuable new stream of data related to the drug utilization of the Medicare population, including individuals who lacked insurance and it also yielded beneficiary contact information that would be useful in future Part D marketing efforts.

Two thought leaders commented on the experience of the community pharmacy sector, both reiterating ideas held a year earlier. Both noted ongoing tension in that sector because of two reasons: the belief that sponsors sought to move business out of community pharmacies and into mail order and their observation that prescriptions filled through the drug card program were less profitable for pharmacies than prescriptions filled on a cash-pay basis. Both respondents also mentioned that the program demanded a lot of pharmacists' time, both to understand the program and to assist beneficiaries in understanding and making choices about the program.

Four respondents commented on the manufacturer experience, each with a different point. One believed that the major impact of the program was the publication of price data on the Internet; he said that manufacturers learned that they did not wish to repeat this public disclosure in Part D. A second stated that the program created price pressure that led to lower prices at the manufacturer level. A third emphasized that the drug card program enabled manufacturers to learn more about dealing with the government and with the Medicare population. A fourth said that the manufacturer impacts of the drug card program were minimal.

A single respondent spoke to the experience of organizations helping beneficiaries, emphasizing the considerable resources that were devoted to outreach and education. Going beyond what was said in Phase I, he added that these organizations had learned that they needed to expand their capacity for the rollout of Part D.

Experience with CMS

Five thought leaders were very positive about CMS, many of them highlighting the agency's evolution between Phase I and Phase II. Three stated that stakeholders felt CMS was a partner and that the Part D regulations and the interpretation of the regulations clearly reflected the fact that CMS had incorporated feedback from stakeholders. Another stated that CMS had improved their communications dramatically over the past three or four years. One respondent believed that stakeholders still found **working with CMS quite challenging due to the combination**

of a compressed timeline, complex requirements, and lack of precise guidance concerning exactly what CMS required.

The Phase II interviews emphasized the lessons that stakeholders had learned in the course of the drug card program. Several respondents said stakeholders were **more knowledgeable** about what they should expect from CMS and what working with CMS would be like.

The Price Compare website remained a salient topic in Phase II as it had been in Phase I. One thought leader believed that making drug prices public was a major accomplishment. However, another believed that there had been a lot of incorrect data published on the Internet and hoped that this problem would not recur under Part D.

Role of Community Pharmacist in Helping Beneficiaries with Drug Benefits and Costs

One thought leader commented on the role of the chain pharmacist in helping beneficiaries with drug benefits and drug costs, a topic that we did not raise in Phase I. In his view, it was **a customer service issue: customers expected their pharmacist to help them with drug benefits and to help them solve problems.** In this person's view, many business owners understood this expectation, but, at the same time, some pharmacists felt frustrated because they viewed themselves as *clinical* professionals and not benefits specialists.

Experience Reaching the Target Population

Many thought leaders had thoughts regarding how to reach the Medicare population on the subject of drug benefits and lessons learned in that arena; most of these ideas had also surfaced in Phase I. Two noted the need to use multiple communications modes. Six emphasized the needs for face-to-face contact and working within community settings, such as senior centers, churches, clubs, and nursing homes. Two commented that it was important to reach out to family members in addition to the beneficiaries themselves. The pharmacy also offered an opportunity to reach the target population about the drug card and about Part D, according to two respondents.

By the same token, these respondents agreed that Internet and extensive print mailings were not appropriate means to reach the target population. Three thought leaders pointed out that messages in the mainstream media were very important and that the drug card program had been hurt by the press's negative attitude toward it. In the eyes of several respondents, this was another area of progress; CMS now understands these important points and is applying them in its Part D communications.

In addition to commenting on modes of reaching beneficiaries, thought leaders addressed the types of messages that were needed. They continued to emphasize the need to present the program in simple and easy-to-understand terms and to avoid overwhelming beneficiaries with volumes of information. One respondent believed that CMS should do more market research to ensure that its desired messages got through for Part D. One highlighted the need for communications campaigns to acknowledge and address the fact that English, literacy, and an understanding of health benefits are not universal attributes. In keeping with a general theme, thought leaders viewed the drug card program as a learning experience; during the program, sponsors and other stakeholders developed new expertise in communicating with the Medicare population on the topic of drug benefits.

Four thought leaders acknowledged that low-income populations are particularly hard to reach. In both Phase I and Phase II, two respondents deemed State Pharmacy Assistance Program's auto-enrollment programs to be successful and contrasted this success with the low levels of enrollment attained in settings where the low-income beneficiary had to initiate enrollment. In Phase II, **respondents extracted a lesson for Part D, namely for a preference making subsidies automatic with opt-out options to increase take up and reduce the burden on Medicare beneficiaries and those who assist them.** One also noted that organizations serving beneficiaries had recognized and were acting upon the need to redouble outreach efforts in communities of color, among dual eligibles, and in other appropriate community settings.

Experience with Enrollment and Beneficiary Choice

In Phase II, **many experts agreed that the health care sector learned that beneficiaries become paralyzed in the face of too many choices.** Reiterating themes from Phase I, five thought leaders said that choosing among drug card options was challenging and that beneficiaries needed help to manage the large number of choices and understand the differences among plans. Three respondents cited the need for better consumer information, one making a comparison to the scorecards used in *Consumer Reports.* At the same time, one respondent pointed out that choice remains an individualized decision without a boilerplate solution; individuals must be supported by one-on-one contact with a knowledgeable person who knows the right questions to ask each beneficiary in order to arrive at the best possible choice for that person. Two believed that some of the challenges were functions of the newness of the idea of choice and that the process would improve over time.

Experience with Sponsor/Manufacturer Partnerships

In Phase II, interviewers pursued additional detail regarding the wrap-programs, in which sponsors and manufacturers worked together to create a relatively seamless transition for eligible beneficiaries from purchasing drugs at negotiated prices using the $600 Federal credit to receiving drugs at reduced prices via the pharmacy assistance programs available from some manufacturers. One thought leader explained that it was the more experienced sponsors who had initially recognized the **value of these partnerships**. Over time, these sponsors had included additional manufacturers into their products and new sponsors had become involved in these types of collaborations. In his view, these collaborations enabled sponsors to offer more value to their customers and enabled manufacturers to publicize their pharmacy assistance programs by capitalizing on sponsors' ongoing marketing efforts and relationships with beneficiaries. **These partnerships also enabled manufacturers to establish relationships with populations who would later receive the full, subsidized drug coverage under Part D.**

A second respondent agreed that the partnerships added significant value to the drug card program and were one of the key drivers of beneficiary savings. He stated that the manufacturers who participated in these programs incurred considerable costs (if they provided drugs at reduced prices to beneficiaries who would otherwise have purchased them at full cost) and received little public credit for their efforts. Therefore, while these programs benefited low-income populations, there was little incentive for manufacturers to participate in them or work to make them effective.

Information Needs, Sources, and Gaps

Drug Card Program, Information for Own Decision Making
According to the respondents interviewed, CMS was a major source of information about the drug card program. One thought leader noted that CMS was not a source for pharmacists because pharmacists did not know whom to call at CMS. In addition, manufacturers turned to the sponsors (specifically the sponsors with whom they already had relationships), consultants, and trade associations. The community pharmacy sector also turned to its trade associations and pharmacists in large pharmacy chains often received informational materials that the chain had developed internally.

When asked about gaps in the information available, no thought leader mentioned a gap in terms of information about the rules and regulations of the drug card program. One mentioned sponsors' unmet need for information about the size of the potential market, i.e. number of beneficiaries and numbers of beneficiaries eligible for transitional assistance by geographic area. The information on market size was also a perceived gap for Part D. Another gap, noted by two respondents, was the lack of information concerning the actual, realized levels of drug card enrollment, including transitional assistance enrollment, enrollment by state, enrollment by drug card, etc. One respondent contrasted the perceived lack with CMS' detailed and frequent publications of enrollment information for the Medicare Advantage plans.

Part D, Information for Educating and Assisting Beneficiaries
Two respondents cited the need for additional information about the drug utilization of the Medicare population, including the utilization of those who had historically lacked insurance and paid cash for their prescriptions; one noted that IMS Health had rapidly developed a product to meet this need.

Discussion

Thought leaders, in Phase I, reported that sponsors' primary reason for participating in the drug card program was to effectively position them for the Part D drug benefit. When asked about CMS in Phase I, thought leaders praised agency staff for having a good attitude and working hard.

In Phase II, **respondents concluded that sponsors and other stakeholders had learned a lot from the drug card program and this learning had been the program's main impact**. Consistent with other stakeholders in Phase II, thought leaders made several positive comments about how **CMS had evolved in terms of its ability to incorporate stakeholder feedback and its communications strategy.** They stated that CMS was viewed as a partner and that the Part D regulations showed the mark of the improvements in its approach.

8.2. Professional Associations

In addition to interviewing individuals who were direct stakeholders in the drug card program, the Project Team also interviewed the professional associations that represented key provider groups.

Description of Respondents

Respondents represented seven professional organizations; all seven respondents were interviewed in Phase I. Constituents included physicians, pharmacists, pharmacologists, pharmacy technicians,

pharmacy students, home health agencies, biotechnology firms, pharmaceutical manufacturers, health insurance plans, and pharmacy benefit managers. Names of the organizations that participated in Phase II may be found in the Appendix E.

Most respondents oversaw Federal policy development and participated in lobbying the Congress and CMS on behalf of their membership. Five respondents provided education and information to their association's membership on Federal policy issues. Two respondents were responsible for strategic planning for their organization and one of these was also in charge of his association's research activities.

Changes in Approach to Drug Card During 2005

All respondents commented that their **activities had not changed** during 2005. In fact, most respondents stated that they had not thought about the drug card in some time. The lack of recent activities related to the drug card program made answering questions difficult, as respondents could not think back that far, had not heard much from their membership on the drug card, and had shifted focus to Part D.

Overall Experience, Impacts, and Lessons Learned

Overall Experience and Impacts

Five respondents declared that the drug card program **did not have any financial, staffing, or other impacts** on their organizations. Of the two respondents that had seen impacts of the drug card, both reported that it was primarily the time and effort dedicated to the drug card. The respondents could not quantify the resource allocation and said it was merely part of their job.

Lessons Learned

The overall lessons learned by respondents included how **best to communicate with their members and beneficiaries on the drug card** and that the benefit was very confusing to all. Both are discussed in more detail below. Respondents did not respond on specific lessons learned regarding low-income beneficiaries. All respondents mentioned their involvement, activities around, and approaches toward Part D. All respondents stated their experiences with the drug card program were beneficial to their rolling out of activities associated with Part D and that the knowledge gained from working with the drug card program was helpful in the crafting of messages around Part D.

Experience with CMS

Similar to Phase I, respondents were generally pleased with their experiences with CMS. Of those that worked with CMS, **most were pleased with the accessibility afforded to them by CMS and were happy with CMS listening to them.** Five respondents positively commented on the **support and communication that they received from CMS**. According to these respondents in Phase II, CMS was increasingly receptive to and willing to work with stakeholders, including providing information and resolving issues.

Through the drug card implementation process, **CMS' efforts evolved and improved**. In particular, conference calls with other States, **continued contact** between the respondent and CMS, and opportunities to ask questions and receive answers in a timely manner were seen as positive aspects of the drug card process.

Consistent with a Phase I theme, respondents stated that CMS continued to disseminate a large amount of material, which was long and intensive. Rather than providing this much material, they needed to scale down the details and provide fact sheets and simple pamphlets.

Role of Community Pharmacist in Helping Beneficiaries with Drug Benefits and Costs

One respondent was able to comment on this issue and stated that, in Phase II, pharmacists continued to play a significant role in educating beneficiaries on the drug benefit and to help beneficiaries choose among the drug card choices.

Experience Reaching the Target Population

Reaching the target population was not the primary role of the respondents. Respondents were responsible for educating their members and lobbying to Congress and CMS on behalf of their members' interests. The majority of respondents provided analyses to their members, conducted train-the-trainer meetings on the drug card program, and gave members tools and material to educate beneficiaries and encouraged enrollment of beneficiaries. Respondents disseminated publications and educational materials to their members, who, in turn, distributed the information to beneficiaries.

While this role was not the direct responsibility of the respondents and their organizations, several respondents commented that it was extremely important to educate beneficiaries with clear, simple, and consistent information. All respondents stated that the drug card program and information circulated was confusing to beneficiaries and the process was extremely complicated. Therefore, in Phase II, respondents **tailored their messages with simple and basic information for their members to disseminate.** Four respondents replied that the drug card program allowed them and their association's members to **determine how to best reach and educate beneficiaries through appropriate marketing and coalitions, definition of messages, and the most appropriate vehicles to reach this population.** Two examples of targeting the information to the respondents' members' population included:

- Putting essential information on a 3 X 5 card for their members to keep in their pocket and to answer any questions from beneficiaries.
- Flyers with State-specific messages and contact information.

Experience with Enrollment and Beneficiary Choice

Three respondents commented on their association's efforts to enroll and help beneficiaries choose among the different drug cards. In Phase II, two respondents provided **train-the-trainer meetings to their members**. While the train-the-trainer activities were well received, members commented that their organizations' members did not have the time to enroll beneficiaries due to the effort needed to explain and educate the beneficiaries on the program and the lengthy enrollment process after the education finished. Similar to Phase I, respondents reported that their members did not help beneficiaries to enroll due to the extreme complexity of the program's process and the time it took away from their duties.

Experience Reaching Providers

Professional associations are responsible for educating and informing their membership. Providers rely on their professional associations, among other sources, for information. In response to members' requests for information and education about the drug card program, professional associations disseminated materials; coordinated teleconferences between CMS, the association, and the members; met with members individually and in groups throughout the country; organized and conducted conferences and trainings; and summarized key points of legislation and other materials.

Professional association respondents found it was important to educate their members early in the drug card program, so the members would have a clear understanding of the drug card program. As members were receiving questions from beneficiaries over the course of the drug card program, respondents received numerous clarification questions and requests for additional information from their members.

Some respondents found that when they and their members attended CMS presentations, while CMS tried to answer all questions posed and wanted to help professional associations and their members, in some circumstances, information from CMS was inconsistent and/or unavailable.

Information Needs, Sources, and Gaps

Drug Card Program, Information for Educating and Assisting Beneficiaries

Respondents were asked about three areas of information surrounding the drug card: needs, sources, and gaps. This section was difficult for respondents to answer and respond because it was hard for respondents to discuss what type of information they needed in their decision-making process, since "they don't know what they don't know." Overall, the six respondents that answered these questions said that they needed to know how the drug card program worked, what drug cards were available, and how beneficiaries could enroll. Several respondents stated that their activities centered on demonstrating the value of the drug card and how the program worked. What was essential to respondents was getting the information out to their member organizations, so the members could get it out to beneficiaries. Through simplifying messages and information distributed by CMS, respondents were able to provide additional material to their members. Among other sources, respondents accessed information on the drug card through CMS, www.medicare.gov, and Access to Benefits.

Even more than in Phase I, five respondents in Phase II stated too much information was distributed and that the disseminated information was confusing. Some respondents stated that the gaps in the information including concise summaries of published material and materials that demonstrated the value of the drug card program. Respondents commented that it was difficult to determine what information was relevant and what information to include in their publications and on their websites. Additionally, three respondents stated that there needed to be information on the beneficial aspects of the drug card, including how the TA worked and the benefits associated with the drug card. Three respondents wished that CMS dedicated resources to demonstrate the validity of the program to the public, stakeholders, and beneficiaries.

Part D, Information for Educating and Assisting Beneficiaries

Respondents were asked about three areas of information surrounding Part D: needs, sources, and gaps. Three respondents said that the needed information for Part D was very similar to their

information needs for the drug card program. Respondents stated that they go to CMS, www.medicare.gov, National Council on the Aging, and Access to Benefits to locate information. Three respondents declared that the distributed information on Part D was timely, responsive, and comprehensive. However, since there was so much information on Part D, respondents, at times, felt overwhelmed with the sheer amount of material, the effort necessary for sifting through it all, and the applicability of information to the respondent's sector.

Plans for Part D

Most respondents discussed their Part D activities; respondents commented that they would conduct activities similar to activities performed around the drug card program, such as education and outreach to the respondents' associations' members. Specific Part D plans included informing constituents of Part D regulations, interacting with CMS regarding proposed rules and regulations, lobbying on behalf of their members, and offering outreach and education to constituents and beneficiaries.

Four respondents discussed how they were applying the lessons they learned about working with CMS on the drug card to the rollout of Part D. While the majority of respondents saw CMS as applying the drug card program lessons to Part D, some respondents had difficulties working with CMS on Part D. Three respondents stated that even with the accessibility afforded by CMS, the scope of Part D created additional bureaucracy at CMS and made it difficult for them to get answers to questions. According to these respondents, CMS seemed overwhelmed with Part D preparations and activities. Two respondents discussed the importance of the material sent by CMS to the stakeholders; similar to comments made about the drug card program, respondents stated that the material needed to be pared down to a one-page document. Additionally, two respondents' needed to go outside of the CMS sources to get the best and most applicable material to disseminate.

Discussion

In Phase I, ten professional association respondents were interviewed. When asked about their reasons for participation in Phase I, respondents stated that they wanted to be perceived favorably by the Administration and the public and they wanted to gain experience with Medicare before the Part D rollout. In Phase II, seven of the ten Phase I respondents were re-interviewed and stated that the **Phase II experiences met the Phase I objectives**. In Phase II, respondents believed that Part D would be more successful than the drug card program due to the implementation and lessons learned from the drug card program. Most respondents were **generally pleased with their drug card experiences** and were thankful that it provided an opportunity to learn prior to Part D.

In Phase II, respondents increasingly commented on the extraordinary accessibility afforded by CMS; this accessibility and responsiveness made the process extremely straightforward and easier to get answers to their questions. Even more than in Phase I, **CMS operated with an 'open door' policy, which allowed respondents to contact them and receive answers in a timely manner**. According to some respondents, **CMS applied the Phase I lessons learned and challenges from the drug card program in their future preparations around Part D**. Additionally, CMS began to distribute Part D information well before the launching of the program, which was suggested by the respondents in Phase I.

9. Results: Community Case Studies

This chapter offers results from the case studies including an analysis of newspaper coverage. The first section of the chapter discusses the results from the community case studies and the second section of the chapter analyzes the newspaper coverage on the drug card program in the same communities.

9.1. Interviews

As part of the Phase II evaluation, the Project Team conducted four community case studies. Community case studies were designed to understand how the drug card program worked at the community level. The Project Team wanted to understand how local, national, and other resources were used; whether there was coordination among various stakeholders, such as the State Health Insurance Program (SHIP) counselors, the Centers for Medicare and Medicaid Services' (CMS) representatives, States, State Pharmacy Assistance Programs (SPAPs), and other community-based organizations; what kind of support local information providers needed and received; what these stakeholders had learned about beneficiary responses and other issues from the drug card program; and how the drug card program experience has shaped their approaches to the introduction of Part D. Unlike most of the interviews described in previous chapters, the case study interviews represented the first time the Project Team had spoken with these respondents and were new lines of inquiry for the project.

Description of Respondents

We selected four communities that were known to have conducted information activities for the drug card program. The methods chapter describes the process of selecting these communities, and the text below offers some background on each:

- **Community One:** An urban county in a mid-sized city. A local governmental agency took the lead in conducting an information campaign in the county and received funding to develop a coalition of other organizations to further expand its outreach and enrollment programs. Several options for pharmacy assistance services were available in the location.
- **Community Two:** A small city and surrounding rural areas. State and local agencies collaborated to implement an information and enrollment campaign primarily directed toward a specific target population. The state's pharmacy assistance program was a key player in the campaign strategy.
- **Community Three:** A large city and its suburbs. Many organizations operated independently in development and implementation of outreach campaigns. One agency in the area used a coalition as part of its strategy. This state does not have a SPAP serving the general population.
- **Community Four:** Two counties in a large urban metropolis. Lead organizations formed a coalition with other service agencies, which were new to Medicare program development. This coalition was funded to conduct outreach on behalf of the drug card program. The state does not offer an official State SPAP, but does offer Medicare beneficiaries access to Medicaid prices for prescription drugs.

Organizations in all four communities were committed to outreach and education regarding the drug card program and shared an emphasis on enrollment of low-income populations. In three communities, **goals were outreach and then assistance for making choices among the drug cards**. In the fourth community, the primary goal was somewhat different: **to enroll eligible beneficiaries into the State's Pharmacy Assistance Program, which was integrated with the drug card program and beneficiaries had a financial incentive to participate.**

Respondents were identified through a "snowball process," as described in the methods chapter, in which we searched for organizations that conducted activities related to the drug card program. In every community, we included agencies that hosted the local SHIP programs, other SHIP officials, State-sponsored Pharmacy Assistance Programs, other pharmacy assistance programs, State and local government agencies, and service agencies that deliver programs such as senior centers, housing, and medical clinics to the elderly, but were not necessarily focused on Medicare issues. About eight individuals were interviewed in each community, for a total of 32 interviews.

Overall Experience, Impacts, and Lessons Learned

Overall Experience and Impacts

Despite the intensive efforts, enrollment in the drug card program in three communities was much lower than expected. Respondents reported that **beneficiaries who were eligible for and interested in Transitional Assistance (TA) were hard to find**. In one community, many individuals in this population were already covered by the State's Medicaid program; in another community, many of those individuals in this income bracket were enrolled in other pharmacy assistance programs. For beneficiaries not participating in other programs, respondents suggested that flaws in the program design, such as the complexity of the program, the number of choices, the use of the Internet as a primary information source, and the lack of value to those not eligible for TA, affected beneficiary interest and enrollment in the drug card program.

Even though they were not successful in enrolling many individuals into the drug card program, these **intensive efforts were expensive.** For some, the additional costs for staffing, volunteers, and event expenses were covered through SHIP funding and grants from the Access to Benefits Coalition (ABC) and the Olgivy Foundation; however, for others, drug card program activities were funded by the agencies' own annual budgets or separate private fund-raising. For those in the latter category, **some respondents noted that participation in the outreach and educational efforts were so costly that other activities, critical to their target populations, had to be put aside.**

In the fourth community, respondents achieved their goals for enrollment in the drug card program and viewed their efforts as successful. While respondents noted that beneficiaries' early responses to the drug card program were generally similar to those described by respondents in the other communities, when the State Pharmacy Assistance Program was integrated with the drug card program, responses changed drastically. When the integration occurred, the SPAP was able to create a substantial prescription drug benefit for beneficiaries up to 200 percent of the Federal poverty level (FPL). The program's card sponsor also provided deeper discounts for beneficiaries whose incomes were between 135 percent and 200 percent FPL. This was followed by a statewide enrollment campaign focused on enrolling eligible beneficiaries into the enhanced State program (and auto-enrolled into one Medicare-approved drug card), eventually increasing membership, according to one respondent, by more than 100,000 new participants. Although respondents saw aspects of their

state's program design as a major factor in their success, they also saw the outreach, information campaign, and the coalition as critical to their successes.

Lessons Learned

Respondents in the four communities reported on what had been successful in their own communities. **Some techniques had been used in previous efforts and were applied to the drug card program; some were learned in the drug card program implementation, which will be applied to Part D:**

- **The development of a campaign approach, as described above, was seen as successful**. Campaigns included commonly designed materials that were used and distributed by participating agencies and the planning of events, such as countywide and statewide enrollment weeks. These campaigns made participation easier for organizations whose primary mission was not Medicare-focused to gain access to training, materials, and Medicare expertise and consultation. Campaigns also garnered other resources, such as media attention and partnerships, to distribute timely information to the public.

- **Coalitions were used in all four communities, although membership and implementation differed widely**. In one community, participants identified a coalition of state agency representatives and the establishment of a statewide structure that included regional Area Agency on Aging (AAA) agencies and identified lead agencies in each county as particularly effective. In this coalition, every participating organization understood its role in the strategy and how each could contribute effectively, thereby decreasing possible territorial and power struggles. Although the State agency had a role in forming the coalition and promoting coordination between the SPAP and the drug card, the coalition, as a whole, led the efforts to publicize the program and encourage enrollment into the program. Respondents saw **strengths in coalitions: effective mobilization of resources, bringing individual strengths and experience to the program, economies of scale in training and material development, a way to develop consistency in messages, and providing identified contact people.** This coalition was further expanded for Part D implementation.

- **The involvement of State and/or local government officials had positive impacts in two communities**, by providing leadership, establishing the importance of the endeavor, and also creating media attention. Respondents stated that government officials could affect administrative and policy change when needed.

- **Respondents reported the need to "get an early start" for Part D**. Many respondents believed the rapid timeline for the drug card had been a problem and appreciated CMS work to create a less compressed timeline for Part D.

- **The funding available through the ABC and Olgivy were extremely helpful; organizations that were provided with additional funding could not have participated in the drug card program to the extent that they did without it.** However, some smaller agencies did not receive supplemental funding for Part D, therefore, limited their outreach efforts and participation in Part D.

Experience with CMS

Experiences with CMS differed among the four communities. Most day-to-day contact was with CMS Regional Offices' (ROs') staff. For example, in one community, respondents reported that t**hey could not have achieved the integration of the SPAP with the drug card program without CMS Central and the ROs' assistance.** At another community, respondents reported **excellent working relationships with the RO staff that provided consultation and support regularly.** At another, although the relationship with the RO staff was generally cordial, some staff were seen as very helpful to the program while others were not expert enough in the program to provide real assistance. At the remaining community, respondents reported almost no contact with CMS during the drug card program, but noted that CMS involvement had increased with Part D implementation. Respondents from some pharmacy assistance programs expressed frustration that significant issues related to planning for the future of the programs and integration of the programs with Part D were unresolved at the time of the community case study (August – October 2005). Other channels of communication with CMS were related to materials, the Internet, and the Medicare call center, discussed in later sections on information needs, sources, and gaps.

Experience Reaching the Target Population

Agencies at all four communities **prioritized identification of low-income beneficiaries eligible for the drug card program.** Despite the extensive outreach and education activities, enrollment rates were low in three communities. Respondents were convinced that their communication campaigns and outreach tactics were successful in reaching many beneficiaries and making them aware of the program; respondents believed that the beneficiaries' negative assessments of the program's design and value led to low enrollment. Respondents reported **a wide range of activities designed to reach target populations, many of which were focused on "going where the population is" and partnering with agencies that already had trusting relationships with the target population.** Respondents also recognized that what works in one location may not be effective in another; the knowledge of the specific communities was important. Outreach activities included the following:

- **Partnering with "non-traditional partners,"** such as agencies that worked with specific populations, e.g., Asian and Hispanic communities, as well as with faith-based organizations. Some respondents suggested it was important that a respected member of the community be involved in the presentation, to form a bridge to a presenter who was unknown to the group. One respondent described an outreach program that hired well-known community members to conduct outreach door-to-door and in other locations in the neighborhood.
- **Partnering with pharmacies** to distribute bags that were printed with Medicare messages.
- **Conducting activities in community settings** such as pharmacies, restaurants, senior centers, medical clinics, senior housing, and libraries, as well as health fairs and street fairs.
- **Partnering with agencies that serve the homebound** such as Meals on Wheels and senior housing.
- **Advertising and publishing articles** in local and city newspapers; public service announcements on television and radio.
- **Mailings to beneficiaries** who were likely to be eligible.

Some respondents noted that **"more is better" in terms of outreach and one could never have too many partners.** Respondents stated that it was important to **saturate the media market** through all methods, such as radio, print, television, newsletters, and presentations, with coverage and efforts that

communicate information to beneficiaries. One respondent likened the campaign to any mass marketing effort, where it is important to present the same, consistent message many times in order for it to register. Other respondents noted that using the coalition approach simplified the process for new partners, who had access to already-developed materials. With coalitions, individuals had "in-house" expertise that they could utilize for any questions that the individual members and organizations might have.

Respondents noted **lessons related to the content of outreach: the importance of simple information that can be easily explained and consideration of how much information the target population is able to absorb at any one time.** Some organizations divided their outreach activities into **multiple step processes** to address this pace of learning (where it takes some beneficiaries more time to absorb and understand), where beneficiaries first learned about the general drug card program in one or more group sessions and later were presented with access to individualized counseling for enrollment decisions and additional questions. While a multi-step individualized approach required time and effort, these respondents believed this level of resources were necessary for effective outreach.

One respondent reported that his goal was to provide only the information each individual needed to know, rather than bombarding them with information not relevant to their situation. Similar to other respondents, the difficulty then, he noted, was how to segment the beneficiaries so information could be directed appropriately. For Part D, this organization is planning to hold sessions that begin with a general presentation, then move to discussions at separate tables in a meeting room, so individuals who share similar situations can gather together for relevant information.

A few respondents, when discussing techniques for outreach, mentioned that low-income individuals may be reluctant to be identified publicly as such; and, it is important to **avoid this type of potential "exposure" of beneficiaries' personal information**. For example, it is important not to advertise a presentation "for individuals who have low-incomes" or to conduct a program in such a way that requires individuals to publicly reveal their incomes.

Experience with Enrollment and Beneficiary Choice

Respondents reported that their organizations had offered extensive assistance with choice and enrollment. In three communities, counselors used the Plan Finder and Benefits Check-Up tools; in the fourth community, most of the focus was on increased enrollment into the integrated SPAP/drug card program. At that community, respondents found the enrollment process easy to complete.

In the three communities where beneficiaries' choice among drug cards was most relevant, respondents reported that most beneficiaries required personal assistance. The process of decision-making was long and cumbersome. It could easily take an hour and beneficiaries' lack of complete medication information further extended the process. Some respondents also noted that the eligibility process for the TA and for Part D's Low-Income Subsidy (LIS), required beneficiaries to reveal personal financial information, which some are reluctant to do. Some beneficiaries might also be concerned about how involvement with "extra help" will affect other benefit programs.

As with outreach, respondents reported that they conducted counseling and enrollment assistance in multiple locations throughout the communities as well as offering telephone enrollment services. Respondents reported that they had developed some processes that increased efficiency and reduced

the time required per client: use of questionnaires and check-lists were distributed to clients for completion before the session so sufficient information was known about medications; some agencies used the material, completed the decision tool, and then contacted clients for further discussion. Another example of an **efficient process took place at a medical clinic**, where staff reviewed medical records to identify individuals who would be eligible for TA, reviewed what the drug card program (in general) could do with the individual beneficiary (since he might not be familiar with it), used a decision tool to match drug cards with the individual's prescriptions, and then helped the beneficiary review the choices generated by the tool and select one of the choices to enroll in.

One gap some respondents saw in the decision and enrollment process for the drug card program was the lack of materials translated into multiple languages. Some agencies had to do their own translations for the program. Respondents also expressed concern about how involved a counselor could get in the actual decision, for example, where the lines could and should be drawn for SHIP counselors or others and how these boundaries might affect beneficiaries' abilities to reach decisions.

Experience Reaching Providers and Beneficiary Organizations

Uniformly, site visit respondents utilized their existing partnerships to disseminate information and educate providers and beneficiary organizations on the drug card program. Additionally, respondents distributed information directly to the SHIPs, AAAs, media, meals-on-wheels organizations, employee health associations, and trade organizations. Respondents employed a variety of methods to educate and inform providers and beneficiary organizations including: conducting train-the-trainer presentations; utilizing newspapers and churches; reaching out to receptionists in physician offices, senior centers, and senior housing associations; and creating "clearing houses" that offered a variety of materials at a single access point.

Most communities had a lead agency within their partnerships that coordinated information dissemination; individuals and other agencies went to the lead agency to get information. For example, one community had State-level coordination and the State SHIP and State AAA operated as middlemen between CMS and local resources.

Site visit respondents discussed their States' and local organizations' outreach to pharmacists. In one State, the SHIP/SPAP coalition used a regional conference to bring together sponsors, CMS, SHIPS, SPAPs, and other key players. Respondents discussed the variation in information pharmacists received depending on how active individual pharmacists were: pharmacists that were active in a coalition or had partnerships received materials and information, however, pharmacists that were not part of a network or did not have partnerships did not have access to the information as readily. For Part D, one State's SPAP provided trainings to pharmacists on what they could and could not say to beneficiaries.

Experience with State / Federal Partnerships

In the community where the SPAP and the drug card program were integrated, respondents observed that the State/Federal partnership had worked well to design and implement the integration. Enrollment into the integrated program was simple; benefits were coordinated automatically through the existing assistance program.

In contrast, in another community, a State government sponsored pharmacy assistance program was not integrated with drug card program. It was perceived that the high administrative costs of implementing the program were not out-weighed by the potential value of the cards' integration. However, members were informed that they could, if they chose to, participate in both the SPAP program and the drug card program and select a drug card on their own. Beneficiaries were notified that the SPAP was not responsible for assisting them in this process. Another governmental pharmacy assistance program existing in this community was also not integrated with the drug card. In this case, beneficiaries would have to leave this government program if they enrolled in a Medicare drug card, then they would spend down the TA and then re-enroll. Sometimes this would create a gap in their prescription drug coverage for some period of time. This community's respondents reported that most beneficiaries participating in other programs with prescription drug benefits were not interested in enrolling in the drug card program. Beneficiaries were reluctant to give up current benefits (which they were required to do) if they moved to a Medicare drug card from one program or to try to integrate programs on their own. In both cases, there was no incentive for beneficiaries to leave their current assistance programs.

Information Needs, Sources, and Gaps

Drug Card Program, Information for Educating and Assisting Beneficiaries

Respondents reported a variety of information that was needed about the drug card program: basic descriptions of the benefit, overviews, contact information, step by step instructions for beneficiaries and counselors for process of selection, tools for choosing among drug cards, instructions for using the tools, and visuals showing cost comparisons among drug cards. Information was needed in the form of fact sheets, posters, "camera-ready" documents that could be delivered in a way that was easily usable, and other materials. Groups who worked with non-English speaking populations needed translated materials and believed that the materials did not exist[21]. At three communities, some respondents asked about the enrollment results for the location; as far as we could determine, enrollment figures had not been distributed. Administrators noted that access to enrollment results would have helped them to continue to refine their outreach campaigns. CMS and the State SHIP programs were the primary sources for information, although some respondents also mentioned the Access to Benefits Coalition, State agencies, and the Kaiser Foundation.

Some of the material described, as necessary, was not available through CMS or other sources. For example, foreign-language materials were frequently translated by the agencies that needed them. Respondents reported that they often had to re-write CMS-generated material and modify presentation slides to simplify the information for their target audiences. A few respondents in one community also reported that CMS sent boxes of unrequested materials for which they had no use and ended up in closets; these respondents would have liked a process by which they could have requested specific materials, rather than having to accept all that was sent to them.

Part D, Information for Educating and Assisting Beneficiaries

Respondents reported that the primary sources of information about Part D were CMS and the SHIP programs. Although they were pleased that CMS had begun to provide information earlier than it had with the drug card program and they found some materials, such as fact sheets, very useful, respondents were still concerned about the program issues that were unresolved at the time of the

[21] In fact, some of CMS materials were translated to Spanish and other MMA materials, found on the CMS website, were translated into Chinese, Korean, Russian, Tagalog, and Vietnamese.

interviews. Examples of unresolved issues at the time of our interviews included: how manufacturer pharmacy assistance programs would be integrated with Part D, how State assistance programs would be integrated or terminated, thorough descriptions of the drug plans and "how they work," how Part D would be integrated with TRICARE and employer plans, and how to access the Plan Finder tool. Some raised communications about the LIS as a problem area: they reported that beneficiaries had received forms and applications but did not know what to do with them. Respondents reported using the CMS website as a primary source; many respondents were also on email list-serves and received regular up-dates from CMS and other sources. Respondents were generally pleased with these vehicles.

Respondents had varying opinions about the information available to them; the variation may be related to the different stages that these respondents were in with their own awareness of the program. Some respondents who are not experts in Medicare issues found it was easy to get lost in the amount of information available and requested help with information management, calendars of events, schedules for resolution of specific topics, publishing schedules, and best practices.

Plans for Part D

Our visits to the communities occurred between late August and early October 2005. Most respondents reported plans to participate in Part D activities, but several small agencies had decided to limit activities to their own client base due to a lack of funding to do outreach to the same extent as under the drug card program. Most respondents noted that their attention had begun to shift away from the drug card program toward Part D in early 2005. Agencies that were taking broader roles in Part D in all communities had been planning and conducting activities for several months.

Many respondents expressed concern about their capacity to respond to requests for assistance with Part D and were trying to develop processes that might alleviate the expected strains on resources. Strategies included expansion of networks and training of other agencies' staff, the more efficient decision processes described above, and some efforts to "empower" beneficiaries and their families to use the decision tools.

Respondents reported plans to conduct outreach for Part D as they conducted under the drug card program, even though respondents noted significant differences between the two programs. Most respondents expect beneficiaries to be much more interested in Part D than they were in the drug card program, some expressed concern that the complex nature of Part D may also be a deterrent to positive beneficiary response. One respondent reported that his agency had conducted a series of focus groups to learn what beneficiaries wanted to know about Part D so outreach and education content could be targeted to beneficiaries' concerns.

In three communities, respondents in lead agencies reported that they had already developed Part D campaign strategies to manage information and education provision in an organized fashion, using similar strategies employed with the drug card program. Although the campaigns differed, respondents mentioned some similar elements, such as the planned use of media and media events, training of government agency staff, training of other professionals in organizations that have daily contact with beneficiaries, and development of materials. For example, during Fall 2005, one lead agency, a county government department, was implementing a roll-out campaign that had already trained all county department directors on how their agencies could help enrollment, directors of county health programs, and State agency staff in the health and social service departments, whose

clients would be affected by Part D. This agency arranged with a local metropolitan newspaper for a special supplement on Part D to be published in November 2005, during the rollout of Part D.

At the time of the visits, respondents described uncertainties that they saw as potentially affecting their activities around Part D. These were issues that had not yet been resolved, but would affect some low-income beneficiaries:

- **How current manufacturer pharmacy assistance programs and State-sponsored Pharmacy Assistance Programs would be affected** by or integrated with Part D.
- **How State Medicaid agencies would resolve differences** between the pharmacy benefit packages of the State programs and the Part D benefit.
- **How access to Part D drug plans** would be determined for beneficiaries in long term care settings.

Many respondents also expressed concern about the required counseling capacity needed to provide the one-to-one assistance to help beneficiaries with enrollment into a PDP. The lead agency at one community was focusing on a fall educational campaign to **"empower" beneficiaries and their families to complete the decision process without help**, hoping that would limit the number of requests for individualized assistance. **At others, the focus was on identifying and training professionals in new "partner" organizations about Part D and the counseling process**.
At the time of the community case studies, there were many unresolved issues about the future of these programs and how the programs would be integrated with Part D, and how the process of transition and termination would occur. Managers of governmental pharmacy assistance programs had plans for providing outreach and information to members. Names and addresses of members had been, or would be, shared with the State's SHIP program so outreach to individuals, assistance with Part D choices, and possible subsidies could be provided. For the one CMS-certified SPAP plan, the one-to-one contacts would be reimbursed. These contacts will assist in beneficiaries' enrollment in a drug plan and completing of subsidy applications.

Discussion

At the local level, people had been working for some time on the issue of getting the Medicare population affordable access to prescription drugs. Each community had its own constellation of possible solutions, potentially including SPAPs and access to free or reduced drugs through Federally qualified health centers or manufacturer PAPs. In some of these cases, the drug card was an awkward fit with existing programs and/or existing programs offered a superior benefit to the one offered by the drug card. Moreover, because of the variability across the country in terms of existing approaches and in terms of the nature of the key players, either CMS or the local community had to custom-fit the drug card program to these existing arrangements.

Several themes emerged from the discussions in these communities. Respondents reported that the community organizations **strengthened their outreach capacities during Phase II** of the drug card program. Those **communities with strong leadership and coalitions seemed to demonstrate a readiness for outreach regarding Part D that was not so visible in the community without a leadership organization.** Respondents perceived that the **program's design features were the primary reasons for the lack of beneficiary response** and low enrollment rates. **Similar concerns were raised about Part D,** in that respondents questioned whether beneficiaries would be able to understand the program, would understand how to obtain financial assistance, and be willing to

engage in a relatively complicated process to select a plan that matches their needs. Some respondents were concerned about staffing capacity to meet the potential demand for counseling for Part D. For example, one organization was responsible for contacting 8,000 beneficiaries that had been served through a pharmacy assistance program. If all beneficiaries needed counseling and assuming the counseling takes an hour, the organization would need to have four professionals working for a year each to provide the counseling.

Reports were mixed on CMS from respondents. Although the drug card program and Part D are CMS responsibilities, **many community-level respondents in this study had tenuous connections** to the agency, such as through use of the website or email function. Smaller agencies tended to look to their network leaders as sources of information. Agencies in leadership roles tended to have more of a relationship with Regional Offices, Central Office, or through the SHIPs. **Leadership agencies reported improvements in CMS communication during Phase II and even more so in Part D**. The pharmacy assistance programs, both private and those associated with government, had significant concerns about integration with Part D that had not been resolved at the time of the visits.

In Phase II, a strong theme that emerged was **success in reaching beneficiaries was tied to the involvement of a community partner.** Another Phase II success was **the use of a coalition leader (or other strong intermediary) who knows about Medicare and drug benefits and possibly has an ongoing relationship with CMS who can be a liaison between CMS and these local partners**.

9.2. Analysis of Newspaper Coverage on the Drug Card Program

As part of the case studies, the Project Team analyzed newspaper coverage of the drug card program in each of the four communities. The aim of this task was to understand the nature and level of media interest in the drug card program and to highlight any significant local variation in program implementation, although the analysis proved unhelpful in the latter regard.

The Project Team searched the main newspapers in the four case study communities. In two communities, we searched one paper; in the other two communities, the Team investigated two papers each. The Project Team also examined senior publications, news monthlies oriented specifically towards seniors in the two communities where they existed. Two Communities, Two and Four, did not have traditional senior publications[22]. The Team examined newspapers from December 1, 2003 – September 2005 using the main newspapers' online archives and senior publications' print copies. Senior publications provided a similar type of coverage as the mainstream newspapers, with news, arts and leisure, and editorial articles. The Project Team used the following keywords: Medicare drug discount card, Medicare drug card, Medicare discount card, Medicare card, Medicare discount, Medicare drug, and discount card. Appendix F offers additional detail on the papers examined, the analysis methods, and the results. The discussion below describes the major community newspapers first and the senior publications second. Broadly speaking, coverage was similar across the four communities; therefore, community-by-community results of the main newspapers are not discussed.

[22] Additionally, the Team examined a senior center newsletter in Community Two that described events and some informative articles that seniors might want to know about. Eight articles in the monthly senior center newsletter discussed the Medicare drug card program; all articles were in the final three time periods. All but one discussed the combination of the state and Medicare's program and encouraged seniors to sign up for the benefit.

Searching on the project's keywords yielded a total of 133 articles: 96 articles in the main newspapers and 37 in the senior publications. For the major newspapers, there were 26 in Community One, 14 in Community Two, 16 in Community Three (two papers: one with ten and the other with six), and 40 in Community Four (two papers: one with 15 and the other with 25). In the senior publications, searching on the keywords produced: 16 articles in Community One and 19 articles in Community Three.

9.2.1. Major Community Newspapers

The majority of articles published in the major newspapers provided basic information on the drug card program with many articles including program contact information for individuals' desiring additional information. About 20 percent of the articles included similar terminology as if they had drawn on common sources; for example, such articles had questions and answers with identical language (18 articles). While the majority of the articles (71) were specific to the drug card program, there were a significant number of articles (24) that offered only a fleeting reference to the drug card program. **Articles that discussed the Medicare website and 1-800-MEDICARE Help Line generally did so in a negative manner, with many offering stories on the large number of clicks that it took to enroll an individual, the wrong answers individuals received when they called the toll-free helpline,** and the problems that continued to exist throughout the drug card program. **Many articles emphasized the drug card program being confusing and overwhelming to beneficiaries.**

Of the total of 96 articles in main newspapers, 28 were published in the five months after passage of the MMA (December 2003 – April 2004). Of these articles, twelve were published in December, the month of the MMA passage. All of these articles discussed the main elements of the new program as a part of a bigger Medicare restructuring effort. Nine of the twelve December articles published eligibility and benefit information on the drug card program. Twelve articles in this five-month period contained similar themes: the confusing nature of the drug card program and the need for beneficiaries to dedicate time and effort to understand how the program can work best for them. Many articles described the Federal and local resources that were available to help seniors out with the drug card program. Nine articles during the period were directed towards or about the organizations involved in providing the benefit, including pharmacists, pharmaceutical manufacturers, and pharmacy benefit managers. Five articles discussed the potential for an increase in prescription drug prices as a by-product of the new law and program. Four articles discussed the impact of the Medicare Modernization Act and the drug card program on Medicare, employers, insurance companies, and Medigap policies.

There were 42 articles published during initial enrollment period of the drug card program (May – September 2004). Twenty-one of the 42 articles published eligibility and benefit information on the drug card. Twenty-one articles in this period highlighted the confusing nature of the drug card program, with at least one article stating that enrolling takes time and effort, beneficiaries need to shop around for the best drug card for their situation, and/or there are numerous resources to help seniors and for additional information. Six articles discussed the problems associated with the website. Twelve articles contended that there was and would continue to be increases in prescription drug prices as a by-product of the new law and program, with two articles conveying the theme that the program would benefit manufacturers and card sponsors and not beneficiaries.

There were eight articles published between October and December 2004. Three of the articles discussed the approaching deadline for the $600 transitional assistance subsidy for the calendar year 2004. Two articles, in separate communities, highlighted problems associated with 1-800-MEDICARE. Three articles discussed the drug card program in a broader discussion of general health care and/or the political election.

There were ten articles published between January and March 2005. Seven articles discussed the program and the approaching deadline to sign up for the drug card program. Of these articles, six provided contact information, methods for enrolling, and/or eligibility and benefit information on the drug card program. Two articles discussed the State sponsored drug card program with little reference to the Medicare drug card program. One article reviewed the program, with the resulting statement that the overarching Medicare restructuring, Part D, and the drug card program are failures.

In the next six months (April-September 2005), seven articles referenced the drug card program. Of the seven articles, three were the same articles bought from the Associated Press and printed in three separate communities. These articles compared the Veterans Affairs' prescription drug benefit to the drug card program and highlighted that the VA received better prescription drug prices when compared to the drug card program. Two articles discussed the State program. All five of these articles emphasized the existence of other programs that could save beneficiaries more money than individuals would save with the drug card program. Two articles published eligibility information on the overall Medicare program, with a limited discussion, but contained eligibility and benefit facts, on the drug card program.

9.2.2. Senior Publications

In addition to analyzing articles in major publications, we also analyzed senior publications because we believed that newspaper coverage might differ between major community newspapers and these specialized publications. Our definition of senior publications was newspapers that were targeted towards seniors and focused on their needs. Using this definition and our contacts in the case study communities, we located two senior publications, one each in Communities One and Three. Communities Two and Four did not have senior publications that met our criteria. Community One publications were published consistent with the calendar months, while the Community Three publication ran mid-month to mid-month; both were monthly publications. We could not locate all publications over the 22-month time period, so a discrepancy exists in our analysis (in Community One, the December 2003 paper and Community Three, November 15, 2004 – December 15, 2004 were missing).

Of the total of 37 articles in senior publications, 12 were published in the five months after passage of the MMA (December 2003 – April 2004). The majority of the articles discussed how the Medicare program was changing and what the legislation meant to seniors. The paper in Community Three published extensive details about the Medicare discount drug card program (1 article filled 2 pages; a second article filled 4 pages). Community One's paper also provided specific elements of the Medicare Modernization Act and on the discount card program. Consistent with a theme seen through all of the senior publications, one article discussed that seniors need to be aware of Medicare scams and fraud and should take appropriate precautions.

There were 17 articles published during initial enrollment period of the drug card program (May – September 2004). Most articles, in this time period, sought to educate seniors about the new drug card

program. Three articles urged seniors to sign up for the discount card program and outlined how to go about learning and signing up for the discount card program. Three articles tried to increase seniors' awareness of possible Medicare drug card scams. Two articles publicized upcoming or recent seminars on the discount card program.

There were three articles published between October and December 2004. One article, published in Community One, discussed the State's drug card program, with a passing reference to Medicare's program. Two articles from Community Three's paper included detailed information of the drug card program, how to complete an application, and urged seniors to sign up for the discount card program.

There were two articles published between January and March 2005: one in each community. Both articles discussed their states' drug card programs, with only a slight mention about the Medicare drug card program.

In the next six months (April-September 2005), three articles referenced the drug card program. Articles from Community One and Three were variable; two (one from each community) placed the drug card program in the larger context of the Medicare drug benefit and one discussed prescription drug assistance alternatives.

9.2.3. Discussion

Analysis of mainstream media and senior publications was not part of Phase I. In Phase II, this analysis of newspaper coverage over the life of the program found that most articles that discussed the drug card program contained references to who was eligible to participate in the program, what benefits existed, and whom to contact if more information was needed. Articles in senior publications were generally longer, contained more detail, and included the benefits and application procedures for the drug card program. Senior publications expanded on the content provided in main newspapers' coverage.

Overall, the focus of the media coverage was concentrated in the early periods, after the passage of the Medicare Modernization Act and during the first enrollment period of the drug card program (100 total: 71 articles in mainstream media and 29 in senior-oriented publications). **These early articles overwhelmingly provided general information on the drug card program, including basic facts and how to get more information**. Articles in the senior publications provided numerous additional details on the Medicare drug card program and the overarching MMA. A few articles attempted to increase seniors' awareness of potential fraud against them. By comparison, articles that were published later often referred to the topics of benefits and eligibility in passing. Unlike the extensive early coverage, only 33 articles were published in the three later periods studied (25 in the mainstream media and 8 in senior publications). In these periods, many articles included only limited references to the drug card program. **Of those articles that discussed the program in-depth, many stated that seniors were not taking advantage of the drug card program, that the program did not live up to expectations, and that other programs existed (State and Federal) that provided better benefits for seniors than did the drug card program.**

10. Cross-Stakeholder Analysis and Summary of Main Findings

In Chapters 3 – 9, this report presented the themes that surfaced from interviews with various groups of respondents: sponsors, community pharmacies, manufacturers, State Pharmacy Assistance Programs (SPAPs), organizations that work on behalf of beneficiaries, and expert observers. [23]

In this chapter, we revisit the major themes from the interviews and summarize results across all stakeholder groups, highlighting areas of convergence and divergence across them, to create a three dimensional view of the program. The emphasis here is on the stakeholders themselves (sponsors, pharmacies, manufacturers, SPAPs, and organizations that work on behalf of beneficiaries), but the discussion is also informed by comments made by expert observers.

Changes in Approach to Drug Card During 2005

Universally, all groups of respondents reported that **they had not changed their approach to the drug card program during 2005.** Some beneficiary organizations had scaled back their outreach in response to limited beneficiary interest and the declining value of the remaining transitional assistance credit. Many respondents reported that their focus had shifted to Part D; some respondents relayed the perception that CMS' focus had shifted as well.

Overall Experience, Impacts, and Lessons Learned

Overall Experience and Impacts

When asked to reflect on their overall experience with the drug card program and its effects on their organizations, many respondents said that the program had required significant effort. For sponsors, it had been a lot of work to get their programs up and running. Pharmacists had to invest a lot of time in educating beneficiaries about the program. Similarly, organizations serving beneficiaries (SHIPs, information intermediaries, and community-level respondents) all commented that it had been time-consuming and expensive to educate beneficiaries about the program and to assist them with the decision and enrollment processes; some continued that their funding and staff resources had not been adequate.

In Phase II, pharmacists and respondents at beneficiary organizations raised a new issue: **the effort required by the drug card led to concerns both about their own upcoming work load during the launch of by Part D and about whether the national capacity existed to meet the challenges of the initial enrollment period.** Beneficiary organizations emphasized that they would need additional funding and staff in order to succeed. Some members of each group seemed very reluctant to get involved in helping beneficiaries with Part D due to their perception of the magnitude and difficulty of this job.

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[23] Chapter 3 also included a brief analysis of secondary data concerning the numbers of approved Medicare drug cards and enrollment into those cards. Chapter 9 described the themes that emerged in interviews conducted as part of community case studies and the results of our monitoring and analysis of newspaper coverage in the case study communities of the drug card program. See these chapters for those results.

Two groups of respondents did not emphasize that the drug card program had been a lot of work. Manufacturers reported a modest impact, and, more surprisingly SPAPs indicated that the program had not been labor intensive either because they used auto-enrollment or because they opted not to coordinate the State and Federal programs.

For the three groups of private sector stakeholders (sponsors, manufacturers, and community pharmacies), **the financial impacts of the drug card program were minimal or negative.** This was consistent with comments in Phase I. More than half of the sponsors reported, unprompted, that they had not made money on the program. Pharmacy executives and pharmacists reported little impact due to low enrollment or a modest decrease in their cash business. Generally speaking, manufacturers, too, reported no effect or a modest financial drain. For States, the program had a positive effect on the bottom line, because, transitional assistance often funded expenditures that would otherwise have come out of State budgets.

Both sponsors and pharmacists did indicate that it had been satisfying to help beneficiaries save money on prescription drugs.

Lessons Learned

The majority of stakeholders agreed that the drug card program **offered a learning experience for Part D and offered insights into administering a drug benefit, working with CMS, and communicating with beneficiaries.** A few stakeholders did argue that the drug card experience was not that relevant to Part D due to structural differences between the two programs.

While the discussion guide did not include direct questions on the experiences of beneficiaries, many stakeholders offered comments in these areas. Stakeholders universally agreed that the drug card program confused beneficiaries and that Part D would confuse them as well, and many expressed disappointment with the low levels of program enrollment. Some stakeholders questioned the value of the program, particularly for beneficiaries who were not eligible for the $600 credit; others, notably pharmacists, emphasized that the $600 credit offered valuable and much needed assistance to those who qualified.

Experience with CMS

As had been the case in Phase I, stakeholders painted a mixed picture of their experience working with CMS in the course of the drug card program. On the one hand, there was a consensus that CMS staff members, both in the Central Office and the Regional Offices, were hard working, dedicated, and wanted to help. At the same time, many respondents described CMS staff as over-stretched and lacking the experience, expertise, and time necessary to carry out their responsibilities effectively. The lack of staff resources at CMS had negative consequences for all stakeholders, particularly sponsors; these consequences were especially pronounced during the program launch.

Some interview respondents reported only limited contact with CMS. These included several pharmacy executives, the majority of pharmacists, and some community-level respondents, notably at one community. For some respondents in the community pharmacy sector, this was a point of bitterness; they believed that CMS was treating them as second-class citizens relative to the sponsors (especially the PBMs) and the pharmaceutical manufacturers. For all these respondents, the lack of an open communication channel with CMS seemed like a missed opportunity given their hands-on role with beneficiaries.

Much more than in the first round of interviews, many private sector stakeholders referred to CMS as an agency that treated them like *partners* in the design and implementation of the drug card program. Sponsors, manufacturers, and pharmacy executives all commented that CMS had become more collaborative over the life of the program and that CMS had become an organization that would listen attentively and respond to their feedback.

Stakeholders noted multiple areas of improvement at CMS. All groups of stakeholders, except for pharmacists, mentioned improvements in the amount of information available and in CMS' ability to disseminate that information. Manufacturers and pharmacy executives also remarked about CMS' increased responsiveness and willingness to compromise. Pharmacy executives also appreciated changes made to the website. **Stakeholders tended to agree that CMS was effectively applying lessons learned in the course of the drug card program to the launch of Part D.**

The drug card caused stakeholders to create or revise their expectations for working with CMS on Part D. In Phase I, sponsors seemed disturbed by the challenges of implementing the drug card. In Phase II, sponsors seemed more sanguine as they looked ahead to Part D. They expected CMS to work hard and want to help, but they also expected a certain level of disorder and change and geared their plans processes accordingly. We observed similar attitudes, to a lesser degree, among beneficiary organizations.

Role of Community Pharmacist in Helping Beneficiaries with Drug Benefits and Costs

Respondents in the community pharmacy sector and some other respondents were asked about pharmacists' role in assisting beneficiaries with issues related to drug benefits and costs. Pharmacists seemed conflicted about their role. They said that they would prefer to focus on clinical and drug therapy issues (not drug benefits issues) and pointed out that they were not financially compensated for work related to benefits. At the same time, many pharmacists accepted these additional responsibilities as part of the customer service aspect of their job and derived satisfaction from the opportunity to help customers in this way.

We also asked these respondents about pharmacists' specific role in helping beneficiaries to make decisions about the drug card program and helping them to enroll in specific cards. In general, pharmacy executives asserted that pharmacists' role was to guide beneficiaries to resources and not to help directly with choice or enrollment. At the same time, most believed that pharmacists *should* be able to provide advice and guidance in choosing the right plan for Part D.

As had been the case in Phase I, it was important to pharmacists that beneficiaries view them as knowledgeable and trustworthy advisors. Some felt they had been in an uncomfortable position of ignorance in the course of the drug card program. At the time of the Phase II discussions, many felt unprepared for Part D and were concerned that this experience would be repeated.

Experience Reaching the Target Population

Virtually all stakeholders were united in the view that **it was hard to reach Medicare beneficiaries, especially low-income beneficiaries, on the subject of drug benefits**[24]. Information intermediaries and community-level respondents also pointed out that it was hard to identify and locate the population segment that would have been eligible for the $600 credit. Respondents cited several factors that made beneficiaries hard-to-reach; some were factors pertaining to the population itself, such as low literacy levels, physical and cognitive impairments, lack of media access, skepticism of government programs, and reluctance to divulge income information/identify themselves as low-income. Others were factors that pertained to the program at hand, such as the program's complexity and beneficiaries' doubts as to whether the drug card program offered greater savings than other, more familiar alternatives. A few beneficiary organizations contended that the target population actually had been reached and that low levels of enrollment stemmed from the fact that the drug card program did not appeal to them.

In the Phase II interviews, stakeholders had reached a clear consensus on the best practices for reaching the Medicare population on the topic of drug benefits:

- **Use a sustained, multi-media approach** with a consistent and well-planned set of messages. Start early. Present information in manageable pieces and allow time for it to sink in.
- **Prepare for one-on-one conversations**.
- **Find community partners and work in community settings**. Work through organizations and individuals that beneficiaries know and trust. About half of pharmacists suggested that the pharmacy could be a key partner in this endeavor.
- **Reach out** to family members and other caregivers.
- **Community-level coalitions and campaigns are effective**; a strong coalition leader (or other intermediary) can often help to bridge the gap between CMS and community-level partners. The involvement of the State government can be helpful in this regard.
- **Do not rely on the Internet** to reach this population.
- **Make messages short, simple, clear, consistent, and customer-oriented**. Use terms that the beneficiary can relate to, and address issues from the beneficiaries' point of view. Emphasize the actions that must be taken.

Experience with Enrollment and Beneficiary Choice

In response to questions about enrollment and beneficiary choice, respondents at beneficiary organizations reiterated a theme from Phase I: beneficiaries needed support to manage the large number of choices and to understand what drug card was the best fit for their personal circumstances. They observed that **the process of helping beneficiaries was extremely time-consuming and that, in the majority of cases, it required personalized, one-on-one attention to the individual beneficiary.** Many of these respondents also noted that they used and appreciated the automated tools to support choice such as tools similar to Benefits Check-Up or Plan Finder tools used with the drug card program. In contrast to Phase I, some pharmacists did observe that it became easier to help

[24] In the drug card time period, many low-income Medicare beneficiaries were eligible for drug benefits through Medicaid and were thus not eligible for TA. Under Part D, this group of low-income beneficiaries will be eligible for the coverage via the private drug plans and will be effectively reached through their existing relationship with state Medicaid programs and through plans to enroll them automatically into a part D private drug plan, if they do not enroll voluntarily.

beneficiaries as time went on due to their greater familiarity with the program. While stakeholder respondents found that many choices were overwhelming to beneficiaries, in Abt's Evaluation of drug card program impacts on beneficiaries, the Study found that beneficiaries rarely considered more than one card and had not sought help in their decisions.

Experience Reaching Providers and Beneficiary Organizations

Across the stakeholder groups, respondents overwhelmingly used existing partnerships to disseminate drug card program information to providers and beneficiary organizations. Respondents also used a variety of other methods to provide information and materials: publishing newspaper and newsletter articles, providing train-the-trainer presentations to beneficiary organization and State agencies, and conducting trainings for all organizations that have regular contact with beneficiaries. Some respondents conducted training and presentations to educate and inform pharmacists and other groups that have direct relationships with pharmacists. Professional associations were central repositories of drug card information for many respondents and other organizations.

Experience with State/Sponsor and State/Federal Partnerships

Several of the sponsors and about half of the States interviewed had been involved in partnerships in which SPAP members were automatically enrolled into a preferred drug card, always with an option to opt out. In general and consistent with Phase I, respondents were pleased with these partnerships. In addition, several information intermediaries observed that auto-enrollment had worked well in their States.[25]

A potential by-product of auto-enrollment and of voluntary enrollment, to a lesser degree, could be coordination between the State and Federal benefit, typically a requirement that eligible individuals exhaust their transitional assistance before invoking the SPAP benefit. In interviews, respondents from SPAPs that had attempted to coordinate with the Federal program described the experience as occasionally challenging, due to the poor quality of CMS' enrollment data or to operational challenges in benefits coordination, but four of five States that had required beneficiaries to exhaust the $600 credit before using State funds said that it had not been difficult to coordinate the two sets of benefits. These SPAPs had resolved some of the problems that they had mentioned in 2004 in interviews conducted by Kim Fox.

One case-study community had met its goals for program enrollment via a three-way partnership between the State, a sponsor, and the Federal program. This community had used auto-enrollment and had fully integrated the Medicare drug card program (including the $600 credit) with the SPAP to provide a more valuable benefit. An active coalition, with State officials as engaged and visible partners, had then mounted a statewide campaign to publicize the enhanced benefit. Both the SPAP and community-level respondents were highly satisfied with the results of this partnership. In this community, beneficiaries enjoyed continued access to a single joint program and enrollment into the drug card program was bolstered by the added value of the State benefit.

In a second case-study community, the SPAP had not attempted to coordinate with the Federal program, citing the administrative burden. Respondents there noted that beneficiaries had been less

[25] Consistent with this finding, Abt's evaluation of the Medicare drug card's beneficiary impacts found that there was a relative increase in participation in the drug card program and in transitional assistance in states with auto-enrollment.

interested in the Federal program because of the existence of the state-level alternative, although, nothing had prevented beneficiaries from enrolling in both programs independently.

Experience with Sponsor/Manufacturer Partnerships

In appropriate interviews, we also inquired about sponsors' and manufacturers' experiences with the so-called wrap programs, in which card sponsors coordinated their drug card offerings (including the Federal $600 credit) with the manufacturers' pharmacy assistance program, which offer reduced-price drugs to qualifying individuals. Several respondents said that these programs had offered beneficiaries valuable access to additional savings but had been administratively complex in some cases.

Information Needs, Sources, and Gaps

Drug Card Program, Information for Own Decision Making

Phase II of the project included questions about stakeholders' information needs. Sponsors and pharmacy executives agreed that, in order to make strategic decisions about their own participation in the drug card program, they had needed information about the program's design, operation, and requirements. In addition, some pharmacy executives and pharmacists had sought information about sponsors' rates of payment, while manufacturers had required the details of sponsors' pricing, payment, and preferred drug lists.

All stakeholders turned to CMS for program information, although, as noted above, many community pharmacists reported minimal contact with CMS. Pharmacy executives, community pharmacists, and manufacturers also received information on individual drug cards from the sponsors. Many large pharmacy chains developed their own materials to educate staff pharmacists about the program, and manufacturers drew upon databases developed by outside vendors in order to understand beneficiaries' drug utilization. SPAPs and beneficiary organizations also consulted their peers, their professional organizations, various coalitions (notably the Access to Benefits Coalition), SHIPs (community-level respondents), and foundations as they sought to understand the program and develop a response.

When asked about gaps in the information available, stakeholders did note various unmet needs, as indicated in Chapters 3-9. **Many stakeholders suggested that CMS has covered the right topics but that information had been late, inconsistent, overly lengthy, or tough to navigate.** Several stakeholders also noted a desire for **information about the actual levels of enrollment** into the drug card program. One expert noted that pharmacists did not know whom to call at CMS. There may be opportunities for CMS to better publicize its informational resources and communication channels for pharmacists.

Drug Card Program, Information for Educating and Assisting Beneficiaries

Interviews also touched on the information that was needed to educate and assist beneficiaries. Many respondents pointed out that it was CMS' responsibility to create a baseline level of community awareness and knowledge of the program; some questioned whether CMS' information campaigns had been effective in this regard. Again, pharmacists and beneficiary organizations seemed concerned that CMS expected them to assume an excessive workload during the launch of Part D.

Pharmacists and organizations serving beneficiaries expressed a desire **for clear, concise, accessible information about the drug card program and about the drug cards being offered, ideally in a format that made drug cards easy to compare.** They often **envisioned one-page fact sheets and checklists that beneficiaries could take home to think about**[26]. Some respondents noted that they had to rewrite CMS' materials in order to make them shorter and simpler; in their view, these materials were still too lengthy and complex for the audience. A few also called for CMS to translate its materials into multiple languages.

In addition, respondents at beneficiary organizations called for instructional information that would help beneficiaries and counselors through the process of making choices and using the available Internet tools. Organizations serving beneficiaries relied heavily upon the Plan Finder tool; several SHIPs noted that this tool worked well for them.

Part D

Generally speaking, **stakeholders' needs for Part D mirrored their needs for the drug card**. Private sector stakeholders needed operational information from CMS and plan-level information from sponsors. Pharmacies and beneficiary organizations also needed educational materials and tools to support their efforts to raise awareness and facilitate enrollment and choice. Several expressed concerns about gaps in the information available and a deeper-seated concern that these gaps reflected unresolved program issues.

Plans for Part D

As background for the discussion of the drug card, we asked interview respondents about their plans for Part D. About half of the sponsors interviewed were planning to sponsor either a private drug plan or an MA-PDP in 2006, many of the remaining organizations intended to partner with or support other Part D plans. Manufacturers and pharmacy executives were making arrangements with individual plans; pharmacy executives were also developing educational materials for staff and customers. Organizations serving beneficiaries were planning and initiating their staff trainings and wider outreach efforts.

[26] Although some respondents were not aware of these resources, CMS had created a number of one-page fact sheets, check-lists, and other brief summaries of key program features and published them on its website.

11. Discussion and Conclusion

Like the Part D drug benefit currently being launched, the Medicare drug card program invites the private sector to deliver a public benefit, seeks to encourage competition among plans, and involves choice of the part of beneficiaries in terms of whether to enroll in the voluntary program and, if so, which drug card to choose. This concluding chapter briefly discusses the impacts and long-term legacy of the drug card program.

For stakeholders, the direct impacts of the program, while real, were short-lived. The program had a limited (but often negative) financial impact on the organizations that worked together to provide the benefit (card sponsors, community pharmacy sector, and manufacturers). Similarly, the program had a finite but significant impact on the organizations that sought to raise beneficiary awareness and help individual beneficiaries make choices because of the time and resources required. Some stakeholders noted that it had been rewarding to offer a needed benefit to the Medicare population, although a few questioned the value of the drug card benefit relative to other available options.

The main legacy of the program was clearly that it offered stakeholders a learning experience that was relevant to Part D and possibly to other aspects of Medicare. In particular, the drug card program established and strengthened networks and relationships among the stakeholders who would later provide the Part D drug benefit. It propelled CMS and beneficiary organizations to develop their approaches to beneficiary outreach and education, and it further engaged the health care community in the challenges that emerge when beneficiaries are called to choose among competing health benefit offerings. Many stakeholders suggested that their experiences with the drug card had been awkward or rough but acknowledged that such roughness was the nature of a learning experience.

As a result of their drug card experiences, stakeholders learned more about the private sector provision of a Medicare drug benefit. Sponsors reported that they had gained valuable expertise in the areas of administering a drug benefit, communicating with beneficiaries, and working with CMS. Many sponsors worked with individual beneficiaries for the first time on the drug card program; in the past, their customers had been institutions. While the drug card program experience led card sponsors to believe that working with CMS on Part D would be challenging, they also said that it would be easier because now they knew what to expect. Pharmacists, too, solidified expectations about Part D based on the drug card experience, although these expectations tended to be pessimistic.

Stakeholders also learned more about voluntary enrollment and choice in the context of Medicare drug benefits. It was very challenging for CMS and its loose network of local partners to raise awareness about the drug card program's existence and basic features. Beneficiaries and the general public remained confused and somewhat skeptical about the new program, phenomena that were exacerbated by the negative political climate and press coverage surrounding the program. Over time, the health care community did develop some best practices for reaching beneficiaries; these practices were described in the preceding chapters. The community pharmacy sector may represent a potential partner in the effort to reach beneficiaries; at present, both they and other stakeholders (including CMS) seem conflicted about their potential role. In addition, it was very challenging and time-consuming for beneficiaries to make choices among competing drug cards and for beneficiary organizations to help them with these choices; many stakeholders expect these challenges to persist into Part D.

While this legacy is important, it should also be considered in light of several points. First, the drug card program was a completely new program and required unfamiliar skills on the part of both the organizations that offered the benefit and the beneficiaries. Many beneficiaries had very limited experience making choices about health benefits; even if they previously had drug coverage, they probably did not actively choose their plan from among a large set of options. Similarly, other members of the health care sector did not have experience with settings in which beneficiaries faced these types of choices. Some of the themes that stakeholders emphasized in the course of our evaluation, such as the level of beneficiary confusion and the effort required to help beneficiaries, may have stemmed from the newness of the program rather that from its intrinsic nature.

It is likely that some of the challenges that stakeholders described may dissipate over time as beneficiaries and the wider community gain experience with Medicare drug benefits and associated concepts. To some extent, the initial stock of knowledge developed in the course of the drug card will transfer to Part D and will ease certain aspects of the Part D launch. At the very least, some of the challenges will be better understood, even if the solutions are not yet fully developed.

Second, although some knowledge gained in the course of the drug card program will transfer to Part D and although some of the drug card experience is probably highly relevant, it is also important to remember that the two programs differ substantially. The financial stakes are much greater for the organizations that will be working together to provide the Part D drug benefit. Moreover, the potential net value of Part D's drug coverage is much greater for many beneficiaries than was the potential value of the drug card combined with transitional assistance. In addition, unlike the drug card program, Part D is expected to be a permanent piece of the Medicare program. Given these differences, it is reasonable to expect that all parties will invest more resources in overcoming the challenges that arise in Part D than were invested in the drug card; among other things, beneficiaries and their families may be being willing to work harder to understand the program and make good choices.

In addition, while some of stakeholders' comments were specific to the new challenges posed by Medicare drug benefits, other comments reflected more general and more familiar concerns. In many settings, the private sector appreciates having input into government policies and being treated like a partner. Pharmacists often voice the desire to be directly compensated for the time they spend counseling beneficiaries. Beneficiary organizations consistently report that their funding is not adequate to meet the challenges of educating themselves and beneficiaries about the ongoing changes in the Medicare program.

A final observation is that most of the respondent stakeholders reached their conclusions on the drug card program quite early in the implementation of the program. There were not significant shifts in perspective between the two rounds of interviews, although there was a decline in the intensity of stakeholders' feelings. The one exception to this observation was that, in the Phase II interviews, stakeholders did report substantial improvements in their experiences working with CMS over the life of the program. On the one hand, this may point to the importance of creating the strongest possible launch and first impression for a new program. On the other, it may be a by-product of the program's short time horizon; by the time we embarked on Phase II of the evaluation, stakeholders' focus was firmly on Part D.

References

Centers for Medicare and Medicaid Services, "Approved Drug Card Sponsor Lists," http://www.cms.hhs.gov/medicarereform/drugcard/sponsorinfo, accessed 06/23/2004 and 03/09/2005.

Fox, Kimberley and Stephen Crystal. *Coordinating Medicare Prescription Drug Benefits with Existing State Pharmacy Assistance Programs: Partnership or Crowd-Out?* Publication forthcoming.

National Conference of State Legislatures. State Pharmaceutical Assistance Programs, January 12, 2005. http://www.ncsl.org/programs/health/drugaid.htm

National Health Policy Forum. The Basics: State Pharmacy Assistance Programs, April 26, 2004, www.nhpf.org

Williams, Claudia; Goodell, Sarah; Hoadley, Jack; O'Brien, Ellen and Kanter, Matt. *State Pharmacy Assistance Programs at a Crossroads: How Will They Respond to the Medicare Drug Benefit?* Published on the Changes in Health Care Financing and Organization's website: www.hcfoorg/pdf/brief0705.pdf

Acronym List

AAA	Area Agency on Aging
AARP	American Association of Retired Persons
ABC	Access to Benefits Coalition
AHIP	America's Health Insurance Plan
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
EDP	Medicare Enrollment Database
FEHBP	Federal Employee Health Benefits Program
FPL	Federal Poverty Level
HPMS	Health Plan Management System
LIS	Low Income Subsidy
MA	Medicare Advantage
MA PDP	Medicare Advantage Private Drug Plan
MCO	Managed Care Organization
MSP	Medical Services Plan
NACDS	National Association of Chain Drug Stores
OIG	Office of Inspector General
PAP	Pharmacy Assistance Program
PBA	Pharmacy Benefits Administrator
PBM	Pharmacy Benefits Manager
RO	Regional Office
SHIP	State Health Insurance Program
SPAP	State Pharmacy Assistance Program
TA	Transitional Assistance
TROOP	Patients' True Out-of-Pocket Expense

Appendix A: Interview Procedures

This report is based on 106 individual in-depth interviews with members of stakeholder groups that have important perspectives on key issues of the drug card program. This appendix offers details regarding the methods used in these interviews.

Overview and Sample Sizes

During Phase I, for each type of stakeholder, we selected an initial target number of respondents based on our expectations regarding how many interviews would be necessary to get a full and complete perspective about the drug card program. (See Exhibit A.1: Sample Development.) For Phase II of the study, the Project Team returned to all 137 respondents that participated in a Phase I interview, and included an additional stakeholder group: State Pharmacy Assistance Programs (SPAPs).

Exhibit A.1

Sampling, Recruitment, and Numbers of Completed Interviews

	Source (A)	Initial Size of Universe	# Of Complete Phase I Interviews	# Of Completed Phase II Interviews
Card Sponsors	**HPMS/CMS**	**76**	**32**	**21**
Manufacturers	**AARP Research/ HDMA Directory**		**16**	**9**
Pharmacies	**NCPDP**	**5,000**	**39**	**28**
Pharmacy Executive		20[27]	17	10
Pharmacists in chain pharmacies		2,500	10	9
Pharmacists in independent pharmacies		2,500	12	9
Organizations Helping Beneficiaries		**51**	**30**	**18**
SHIPs program directors	SHIP resource center	51	22	11
Info intermediaries and beneficiary advocates	Public sources	13	8	7
SPAPs	**CMS, public sources**	**18**		**14**
Experts	**CMS, public sources**	**23**	**20**	**15**
Professional associations		12	10	7
Thought leaders		11	10	9
Grand Total of Interviews Included in Report			**137**	**106**

(A) All sources will be explained in depth following this exhibit.

[27] Based on sampled pharmacists. Please see text.

Sample Sources and Selection Methods

Card Sponsors

Our design called for interviews with general, exclusive and special endorsement card sponsors. During Phase I, CMS provided us with sponsor contact information from a current run of the Health Plan Management System (HPMS) on October 20, 2004. CMS recommended that the Medicare Compliance Officer listed in the database for each sponsor would be the most appropriate representative for the interview. The HPMS data contained contact information for the Medicare Compliance Officers of 30 general card sponsors, six special endorsement card sponsors, and 40 exclusive card sponsors.[28] More than half of the time, the Medicare Compliance Officer in our sample referred our recruiter to a more appropriate person to approach for the interview. For Phase II, we sent recruitment emails to all 32 sponsors that participated in Phase I either by a phone interview or a case study. We completed 21 interviews with sponsors for the Phase II Final Report.

Manufacturers

For Phase I, our initial list of manufacturers was based on research done by the American Association of Retired Persons' (AARP) on the Top 200 National Drug Codes (NDCs) by number of prescriptions for the elderly in 2003.[29,30] From this list we selected the top 12 brand-name manufacturers and randomly selected another five brand-name manufacturers from those remaining on the list; we also selected the top five generic manufacturers. For each manufacturer we identified the appropriate contact person by referring to the 2004 Healthcare Distribution and Management Association Directory (HDMA) and sent these individuals recruitment letters. For Phase I, we completed 16 interviews with manufacturers. In Phase II, nine of these 16 respondents participated in a Phase II interview.

Pharmacies

Our design called for interviews with lead pharmacists in independent pharmacies, executives at pharmacy chains, and pharmacists in chain pharmacies. During Phase I, we purchased data on 5,000 pharmacies in the U.S. from the National Council for Prescription Drug Programs, Inc. (NCPDP) in November of 2004.[31] This list consisted of 2,000 chain pharmacies, 500 chain grocery pharmacies, and 2,500 independent retail pharmacies.[32] From this list, we excluded pharmacies in Guam, Puerto Rico and the Virgin Islands because our evaluation was limited to U.S. states where the drug card program was implemented.

Independent Pharmacists*:* In Phase I, we selected a random sample of 50 independent pharmacies from the NCPDP list and called these 50 pharmacies to identify the names of the lead pharmacist or

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[28] The special endorsement sponsors also sponsored national cards and therefore we were able to discuss issues regarding their experiences with both general and special endorsement cards during interviews

[29] May 2004. AARP "Trends in Manufacturer Prices of Brand Name Prescription Drugs Used by Older Americans, 2000 through 2003. David J. Gross, Stephen W. Schondelmeyer, and Susan O. Raetzman.

[30] Because the data were collected in this way, drugs administered in a physicians' office and covered by Part B were not included.

[31] The NCPDP list has over 70,000 licensed pharmacies and is updated annually.

[32] Our sampling of chain pharmacies was based on market share of prescription drug sales from the National Association of Chain Drug Stores website: www.nacds.org.

owner of the pharmacy. For Phase II, we emailed all 12 independent pharmacists that participated in a Phase I interview. Nine of these 12 participants participated in a Phase II interview.

Pharmacy Executives and Chain Pharmacists: In Phase I, we selected a random sample of 50 chain pharmacies from the NCPDP list in order to meet our initial goal of 25 interviews,[33] including no more than six stores from any one chain in our sample. Our sample of 50 chain pharmacies contained stores from 20 unique chains. Project staff called the pharmacies in order to identify the names of the lead pharmacist or owner of the pharmacy.

Before sending out the recruitment letters to pharmacists, our recruitment strategy was to interview the pharmacy executive of the chain first in order to ask the executives to encourage the chain pharmacists to participate in our study.

We sent recruitment letters to the pharmacy executives of all 20 unique chain pharmacies in our sample. A representative from the National Association of Chain Drug Stores (NACDS) provided us with contact information for the pharmacy executives of the chain pharmacies. We completed 17 interviews with pharmacy executives during Phase I. For Phase II, 10 of these 17 respondents participated in a Phase II interview.

For Phase I, once an interview with a pharmacy executive from a chain pharmacy was completed, we sent recruitment letters to the sampled chain pharmacist from his/her chain.[34] In Phase I, we completed 10 interviews with chain pharmacists. For Phase II, nine of these 10 respondents took part in a Phase II interview.

State Pharmacy Assistance Programs

State Pharmacy Assistance Programs (SPAPs): In Phase II, we added the SPAP stakeholder group to our interviews. Drawing on a CMS publication, we sent recruitment letters to 18 of the 21 SPAPs given transitional grant distribution awards. Abt sought to include states in which an SPAP offered benefits to the general population of low-income seniors and was potentially able to offer its members access to TA. Abt excluded three states in which SPAPs that only offered benefits to individuals with certain medical conditions or all SPAPs operated under 1115 waivers and their members were therefore ineligible for TA. The three that we did not recruit were not eligible to participate given the programs' characteristics and beneficiaries. Of the 18 who were sent letters, we completed 14 interviews (12 via telephone and two in person during our community case studies).

Organizations Helping Beneficiaries

State Health Insurance and Assistance Programs (SHIPs): In Phase I, our sample of SHIPs program directors from the state-level offices was from the April 2004 list of 51 state SHIP project directors (50 states and the District of Columbia) from the SHIP Resource Center. We completed 22 interviews with SHIPs project directors in Phase I, and 11 of these 22 respondents participated in a Phase II interview.

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[33] We only included up to 6 stores from one chain in our sample.

[34] Three pharmacy executives did not grant us permission to interview their line pharmacists and therefore we did not recruit these pharmacists.

Information Intermediaries: For Phase I, we interviewed eight representatives of advocacy organizations for Medicare beneficiaries. We consulted with CMS, SHIPs coordinators and state representatives to identify appropriate organizations, and selected those with the greatest national prominence. Once organizations were selected, individual respondents were identified from public data sources and were interviewed. For Phase II, seven of the eight respondents participated in a Phase II interview.

Experts

Thought Leaders: For Phase I, an initial list of thought leaders was developed using individuals cited in the news, professional contacts of the Project Team, and recommendations of CMS. We then used a snowball strategy (asking each respondent for names and qualifications of other potential respondents) to generate additional names and to identify the most promising candidates. The final list of eleven respondents was selected with an eye to balance in terms of expertise, to intellectual distinction, and to the ability to speak in an informed and candid way about the drug card program. For Phase II, nine of these 10 respondents participated in a Phase II interview. The one who did not, Kim Fox, had become a consultant to our project.

Professional Associations: We interviewed 10 individuals who represent prominent national and regional professional associations for the stakeholders in our study; these individuals were public policy directors for their respective professional associations, who specialize in Medicare issues.[35] Once the list of professional associations was compiled in conjunction with CMS, we used public data sources to identify individuals to interview, sent them recruitment letters, and completed the interviews.

Recruitment Procedures

All interviews included in this Phase II Final Report were conducted between August 24, 2005 and November 21, 2005. Potential respondents from all interview groups except SPAPs were emailed an advance recruitment letter from Abt's Project Director, as well as a disclosure statement (described below).[36] A member of the project staff followed up with a telephone call to answer questions about the study and to schedule an interview if the respondent was interested in participating. Recruitment continued until the respondent either: scheduled an interview, refused to participate, or fell into the category of "passive refusal" in which the Project Team left at least five unreturned voice messages. In conjunction with the recruitment letter and again at the time of the interview, all potential respondents were informed of the purpose of the study, its confidentiality procedures, and the fact that participation was voluntary.[37] All respondents received a reminder telephone call or email 24 hours in advance of their scheduled interview. Interviews were conducted by eight of Abt's senior project staff. Many interviews also had a note-taker for quality control purposes and for assistance with writing the interview summary. Respondents were informed that an additional researcher was listening in on the interview to take notes. After the interview was complete, respondents were sent a thank you email.

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[35] See Appendix E for a List of the Thought Leaders and Professional Associations

[36] SPAPs were sent this information via regular mail, since they did not participate in Phase I of the interview and we did not have their email addresses.

[37] A letter and accompanying interview script, approved by Abt Associates' Institutional Review Board, was used to explain these procedures and protections.

Confidentiality and Informed Consent

As in Phase I, the Abt Associates Institutional Review Board (IRB) reviewed and approved the Phase II study protocol, including the disclosure statement (see below), interview discussion guides, recruitment strategies and materials, and a data security plan. We used a disclosure statement rather than a signed informed consent form due to the difficulties inherent in obtaining a signed form prior to a telephone interview.

Respondents were given information related to the disclosure statement several times. When they were first recruited, potential respondents received the disclosure statement along with the recruitment email/letter. During the scheduled time for the interview, interviewers read the consent script, which described the purpose of the study and other key points from the disclosure statement (e.g. that participation in the study was voluntary and that participants did not have to answer questions they did not want to). Respondents were not given any monetary or other compensation for participating.

All respondents, with the exception of thought leaders and representatives of professional associations, were assured that their confidentiality was protected and that their names and organizations would not be included in our report. With their permission, thought leader's names and the names of participating professional organizations are included in Appendix E.

Interview Protocol Design

In collaboration with CMS, the Project Team developed the Phase II interview discussion guide. Each stakeholder group's discussion guide contained the same set of core question, as well as questions specific to each group. The discussion guides contained open-ended questions, which asked about overall experience with the drug card program, any changes in approach to the program in year two, experience reaching the target population, experience working with CMS, experience with enrollment and beneficiary choice, and lessons for the Part D drug benefit.

Interview Procedures

The interviews were designed to take 30 minutes, with the exception of sponsors' interviews, which required 45 minutes because more topics needed to be covered. Most interviews were completed within the allotted time.

All interviewers and note-takers participated in a half-day training. This training oriented staff to the substantive issues related to the project, data collection and recording processes, and informed consent procedures. Interviewers and note takers also participated in a second half-day training focused on interviewing skills, reviewing the interview protocols and recruitment criteria. All interviewers were carefully trained to ensure that they would maintain a neutral position throughout the interview.

Analytic Methods

When two staff members conducted an interview, the more senior person led the interview and the junior staff member took notes. Immediately after the interview, the note taker summarized the interview using a report summary template called the "recording form." The senior interviewer reviewed the summarized notes in the recording form to ensure accuracy. The recording form was

formatted for importing into an NVivo (version 2.0) software database.[38] A coding scheme for the interviews was developed to assist in the data analysis. The final coding scheme consisted of structural codes that mirrored major sections in the interviewer's protocol, and were similar for all interview groups. NVivo was used to sort the data by question for each interview group. Some stakeholder groups with a larger number of interviews were further coded for sub-themes of each major topic. Using NVivo allowed all interviewers to analyze how many times a particular theme was raised and by whom, in order to ad rigor to the process of documenting widely held views. The senior staff member responsible for doing the majority of interviews for a stakeholder group was assigned to write the related chapter for this report. All the interviewers who conducted interviews with a given stakeholder group together discussed emergent themes several times before and while writing a chapter on a stakeholder group.

[38] Software like NVivo is commonly used to manage and review a large volume of qualitative data in an objective and scientific manner and to document the basis for any conclusions.

Appendix B: Interview Discussion Guide

Question Number	Full Question	Sponsors	Ph Execs	Chain Ph	Ind Ph	Site Vs Info Interm	Site Vs SPAPs	Manufax	SHIPs	SPAPs
1	**Background**	X	X	X	X	X		X	X	
2	Briefly describe your organization						X			X
3	Confirm Phase I description of the organization. Has anything changed about your organization since the last time we spoke? (mission, products, clientele, etc.)	X	X	X	X	X		X	X	
4	Confirm Phase I description of role in organization. Has anything changed?	X	X	X	X	X		X	X	
5	Briefly describe your role in your organization.						X			X
6	Briefly describe your organization's plans for the Part D prescription drug plans.	X	X		X	X	X	X	X	X
7	What, if any, is your role in your organization for Part D?	X	X			X	X	X	X	X
8	Please describe any changes your organization has made to your approach to the drug card program since Jan 1.	X	X	X	X	X	X	X	X	X
9	(If changes) What was your motivation for these changes?	X	X	X	X	X	X	X	X	X
10	(If changes) What was the result of these changes?	X	X	X	X	X	X	X	X	X
11	**Overall Experience**	X	X		X	X	X	X	X	X
12	What have you seen as the impacts on your organization of the Medicare drug card program? (probe for financial, staffing, etc.)	X	X		X	X	X	X	X	X
13	What lessons has your organization learned as a result of your experiences with the Medicare drug card?	X	X		X	X	X	X	X	X
14	(If organization is participating in Part D) How will you/are you applying lessons learned from the drug card program to Part D?	X	X		X	X	X	X	X	X
15	If not, describe how the drug card experience affected your decision-making regarding Part D.	X								
16	What are the particular lessons concerning low income beneficiaries /subsidized benefits?	X	X		X	X	X	X	X	X
17	**Overall Experience with CMS**	X	X		X	X	X	X	X	X
18	What lessons has your organization learned about working with CMS as a result of your experience with the Medicare drug card?	X	X		X	X	X	X	X	X
19	How are you applying these lessons in your preparations for Part D?	X	X		X	X	X	X	X	X
20	**Role of Chain Pharmacy Sector**		X	X	X					
21	Please talk a little bit about your experiences helping beneficiaries to understand the Medicare-approved drug card program, decide whether to enroll, and decide which card to choose. Probe: what types of questions did beneficiaries ask you? what types of help did they want from you?									
22	How do you see the chain pharmacy sector's role in terms of helping customers with issues related to drug benefits and cost? Please talk about what your role is and about what your role should or could be.		X	X	X					
23	Please talk a little bit about your experiences to date helping beneficiaries to understand Part D. Probe: what types of questions do beneficiaries ask you? what types of help do they want from you?		X	X	X					
24	**Experience Reaching the Target Population**	X	X	X	X	X	X	X	X	X

Question Number	Full Question	Sponsors	Ph Execs	Chain Ph	Ind Ph	Site Vs Info Interm	Site Vs SPAPs	Manufax	SHIPs	SPAPs
25	Please describe your organization's efforts (if any) to raise awareness and educate beneficiaries about the Medicare drug card program. Please focus on how your efforts have evolved since the last time we spoke.		X		X	X	X		X	X
26	Describe your organization's marketing efforts to beneficiaries, including any use of partnerships? Please focus on how your efforts have evolved since the last time we spoke.	X								
27	How have you attempted to distinguish your organization's marketing efforts from competitors for the drug card program?	X								
28	What lessons did your organization learn about how to reach the Medicare population on the subject of drug benefits? (Probe for modes of communication, best way to craft messages, best way to segment the population.)	X	X		X	X	X		X	X
29	Please describe any particular lessons relevant to low-income Medicare beneficiaries (eligible for TA with drug card and subsidies with Part D)	X	X		X	X	X		X	X
30	How are you applying these lessons in your preparations for Part D?	X	X		X	X	X		X	X
31	Did your organization participate in the MSP program?	X								
32	If yes, discuss your experience with this?	X								
33	**Experience with Beneficiary Choice and Card Enrollment**	X	X	X	X	X	X	X	X	X
34	Please describe your organization's efforts to support beneficiaries in choosing a Medicare drug card and in enrolling in that card. (Probe: did these efforts change over time? How did you see your role - give information, offer advice?) _		X		X	X			X	
35	What lessons did your organization learn about how to support beneficiaries in choosing among various Medicare drug benefit options?		X		X	X	X		X	X
36	How are you applying these lessons in your preparations for Part D?		X		X	X	X		X	X
37	**Experience with State / Federal Partnerships: Enrollment**					X	X		X	X
38	Please describe your state's efforts to encourage SPAP members to enroll in Medicare drug cards. (Probe: did you do auto-enrollment, etc. Probe: what went well? What didn't go so well?)					X	X		X	X
39	Was there other state or local efforts to reach out to targeted populations about the Medicare drug card and the $600 credit? Describe. (Probe: what went well, what didn't go so well?)					X	X		X	X
40	What lessons did your organization learn from these experiences?						X			X
41	How do these lessons apply to preparing for Part D?						X			X
42	**Experience with State/Sponsor Partnerships**	X					X			X
43	Please describe any partnerships/collaboration between your organization and any state / your state and particular drug card sponsors to promote enrollment in Medicare drug cards. (Probe auto-enrollment etc.)	X					X			X
44	What lessons did your organization learn from these experiences that are applicable to Part D?	X					X			X
45	**Experience with State / Federal Partnerships: Coordination of Benefits**					X	X		X	X
46	Please describe your state's efforts to co-ordinate benefits between your SPAP program and the Medicare drug card / TA program.					X	X		X	X
47	What lessons did your state learn from these experiences?						X			X

Question Number	Full Question	Sponsors	Ph Execs	Chain Ph	Ind Ph	Site Vs Info Interm	Site Vs SPAPs	Manufax	SHIPs	SPAPs
48	How do these lessons apply to preparing for Part D?						X			X
49	**Experience with Sponsor/Manufacturer Partnerships: Coordination of Benefits**	X						X		
50	Have you been involved in any partnerships between Medicare drug cards & manufacturer PAPs? Please describe.	X						X		
51	Describe the opportunities for similar partnerships between the Part D plans & manufacturer PAPs	X						X		
52	**CMS Communications: Own Decision Making**	X	X		X		X	X		X
53	What types of information did/does your sector need for its own decision-making about the drug card?	X	X		X		X	X		X
54	What were your sources of that information?	X	X		X		X	X		X
55	What were the gaps in that information?	X	X		X		X	X		X
56	What types of information did your sector need for its own decision-making about Part D?	X	X		X		X	X		X
57	What are your sources for that information?	X	X		X		X	X		X
58	What are the gaps in that information?	X	X		X		X	X		X
59	**CMS Communications with R's Sector to Support Beneficiary Decision-Making**		X		X	X	X		X	X
60	What types of information did/does your sector need in order to educate beneficiaries about the drug card and support them in their decision-making?		X		X	X	X		X	X
61	What were your sources of that information?		X		X	X	X		X	X
62	What were the strengths and weaknesses of those sources? Probe: what were the gaps in that information?		X		X	X	X		X	X
63	What types of information does your sector need in order to educate beneficiaries about Part D and support them in their decision-making?		X		X	X	X		X	X
64	What are your sources for that information?		X		X	X	X		X	X
65	What are the strengths and weaknesses of those sources? Probe: what are the gaps in that information?		X		X	X	X		X	X
66	**Closing Questions**	X	X	X	X	X	X	X	X	X
67	Is there anything else you would like to add? Anything important that has not come up?	X	X	X	X	X	X	X	X	X
68	Confirm contact information.	X	X	X	X	X	X	X	X	X
69	Thank you.	X	X	X	X	X	X	X	X	X

Appendix C: Focus Group Discussion Guide

Medicare Drug Card Evaluation: Stakeholders' Experience

Focus Group Discussion Guide

Introduction

Hi, my name is _____, and I work for a company called Abt Associates. We are doing a study with the College of Pharmacy at the University of Minnesota on how the Medicare program is working for people. I'm here today because we are inviting pharmacists to provide feedback on the drug card program. We'll be holding a total of four focus groups with pharmacists, in two cities around the country. In addition to these focus groups, we are conducting approximately 150 interviews with various stakeholders around the country such as drug card sponsors, manufacturers, pharmacists, and state representatives. Before we get started, I need to read aloud part of the consent form, which you have signed.

Informed Consent

The study is sponsored by the Centers for Medicare and Medicare Services (CMS). Abt Associates Inc. is the company conducting the study with input from the University of Minnesota's College of Pharmacy. The purpose of the study is to find out about various people's experiences and perspectives concerning the drug card program, including pharmacists' experiences and perspectives. The findings from this study will be used to give CMS feedback on the drug card program and will help inform Medicare drug benefit policy.

Your participation in the study is voluntary. You do not have to do this or any research study and you do not have to answer any questions you do not wish to answer. If you decide to participate in this study right now, and later change your mind during our discussion, you may step out at any time. If you choose not to participate or step out, you will not be punished or damage your relationship with Medicare in any way. We do not think there is any risk to you if you participate in this discussion group, and there may be a benefit to you, to hear what others have to say about their experiences with the drug card program. Does anyone have any questions?

How the focus group will work:

- This focus group will take about one and one-half hours.
- We want to keep the discussion informal and relaxed
- Feel free to use the restroom as you like since we don't have a planned break
- Others may be observing the group behind the glass, including people from CMS.
- The group is being videotaped and audio taped. The tapes will be used for writing our reports and will be shared with staff from CMS. The tapes will not be shown to anyone outside of the Medicare program staff. While those staff will see the tapes, they will not know the last names, address, phone numbers, or work-places of the people in the group, i.e. they will not have access to any of the information that was used to recruit you only to what you say in the group. Your confidentiality is protected.

- During the discussion, please feel free to ask each other or me questions if something is not clear. However, I want to let you know that I am not an expert on Medicare nor can I answer your questions about the drug card.
- In order to protect your confidentiality and the confidentially of those in the group, you cannot discuss what is heard or said during the focus group with others.
- There are no right or wrong answers – we are here to learn from your experiences.
- If you disagree with what someone else says, or have a different experience, please say so or I'll think that you all agree. Our purpose is to have a discussion.
- Some of you may have strong opinions about the topic we'll be discussing; please be respectful of other's opinions.
- Be careful not to talk all at once; I don't want to miss anything that is said.
- My job is to make sure we hear from everyone. Some people talk more than others, and I'll be encouraging everyone to speak up.

Does anyone have questions about anything I have said so far?

Background Information:

1. Please say your first name and a few words about your pharmacy, including whether it is an independent or chain pharmacy, but do not mention the pharmacy.

2. Again, making your best guess, what percentage of your prescriptions is filled for Medicare beneficiaries?

    - Under 10%
    - 10% - 20%
    - 20% - 30%
    - 30% - 40%
    - 40% - 50%
    - Greater than 50%

[Note for moderator – The elderly on average account for 42% of all prescriptions.]

Discussion Questions:

Overall Experience:

Moderator: *The drug card program and the $600 credit (TA) were the first steps in the launch of the new Medicare drug benefit. The second step will be the introduction this winter of the new Medicare Prescription Drug Plans, which offer drug insurance to Medicare beneficiaries. Today we want to focus on your experiences with the Medicare drug cards.*

3. For you as a pharmacist, what were the impacts of the drug card program?
    Probe: what were the impacts on your practice?
    Possible probe: what impact did the drug card program have on your pharmacy as a business?

4. Were you required to spend a significant additional time with Medicare customers as a result of the drug card program?
   Probe: How much of this time was related to helping beneficiaries decide if they wanted to enroll in a drug card?

   Probe: How much of this time was related to helping beneficiaries select a specific drug card?

   Probe: How much of this time was related to helping those with Transitional Assistance (the $600)?

5. Can you talk about any difficulties you may have had getting the TA ($600) balances for customers?
   Probe: What types of problems did you have with the TA?

   Did you have to make phone calls or other special efforts to get this information? If yes, please explain.

6. Did many of your Medicare customers have insurance or other discount cards that needed to be coordinated with the Medicare drug card?
   Probe: If yes, can you discuss any difficulties with this?

7. What factors affected whether individual beneficiaries decided to enroll in a drug card?

8. What lessons have you learned as a result of your experiences with the drug card program?

9. How did you apply these lessons to your practice over the life of the drug card program? Did your practice change over the life of the program?

10. How do these lessons affect your plans regarding the new Medicare prescription drug plans (Part D)?

Role Of Chain Pharmacist in Helping Beneficiaries to Understand and Make Decisions about Drug Benefits:

11. In general, what kinds of questions about drug benefits do Medicare beneficiaries ask you as a pharmacist?
    Probe: What type of help do they want from you?
    Probe: What sort of help do you provide, even when they don't ask for it, perhaps because they don't know what to ask for?

    [*We are interested in questions about drug insurance, how to pay for prescription drugs, and how to cut out-of-pocket drug costs rather than clinical questions about how drugs work and which drugs are best for a particular patient]*

12. Now, what kinds of questions have they specifically asked about the drug card program and the $600 credit?

13. Can you talk about your role in helping Medicare beneficiaries to understand the drug card program?

14. Can you talk about your role in helping Medicare beneficiaries decide whether to enroll and decide which drug card to choose?
    Probe: What role do you think community pharmacists should be taking in helping beneficiaries with choice in the program?

15. What types of questions have Medicare beneficiaries been asking you about the new Medicare prescription drug plans?

Ideas for Reaching the Target Population:

Moderator: *CMS would like to continue to reach as many beneficiaries as possible that would be eligible for the $600 credit (Transitional Assistance). These beneficiaries will most likely be eligible for the low-income subsidy under the Medicare Prescription Drug Coverage program. This is a difficult population to reach because these are often low-income people with limited access to the media and limited ties to the healthcare system.*

16. First of all, do you think you know which of your Medicare customers are likely to qualify for the $600 credit/TA?

17. What ideas do you have about reaching this population?
    Probe: Modes of communication, approaches to segmenting the populations / particular groups to think about, most compelling messages.
    Probe: Do you have ideas about how pharmacists might be able to play a role in reaching this population?

18. What have you been doing differently during the second year of the drug card program, in order to reach these Medicare beneficiaries?

Information Needs, Sources, and Gaps:

19. What types of information about the drug card program did/do you need, both for yourself and to have available for beneficiaries?

20. Where do you go to get this information?

21. Were/are there any gaps in the information available to you?
    Probe: Can you talk about the strengths and weaknesses of the information available to you?

22. What types of information about the new Medicare prescription drug plans do you need?

23. Where do you go or plan to go to get this information?

24. Are there any gaps in the information available to you?
    Probe: Can you talk about the strengths and weaknesses of the information available to you?

Perceptions of the Program's Benefits to Beneficiaries:

25. Do you think beneficiaries have benefited from this program? If yes, how so?
    Probe: Specifically, what do you think were the benefits of the drug card program for those who qualified for the $600 credit /TA?
    Probe: What do you think were the benefits of the drug card program for those who did not qualify for the $600 credit/ TA?

Expected Challenges During the Transition from the Drug Card Program to Part D:

26. What do you see as some of the challenges for pharmacists during the transition from the drug card program to the Medicare prescription drug plans?

Appendix D: Drug Card Fees

Exhibit D.1

Number and Percent of Drug Cards with Fees and Average Fee in 2004 & 2005

	2004		2005	
	N	**Pct**	**N**	**Pct**
All Drug Cards	**155**		**166**	
Number of cards with fee	65	42%	65	39%
Average fee, cards with fee	$23.64		$23.03	
General Cards	**73**		**73**	
Number of cards with fee	61	84%	61	84%
Average fee, cards with fee	$23.22		$23.29	
Exclusive Cards	**82**		**93**	
Number of cards with fee	4	5%	4	4%
Average fee, cards with fee	$30.00		$19.06	

Sources: CMS Website 06/23/2004 & 03/09/2005

Appendix E: Respondents (Expert Observers Only)

Thought Leaders

Joseph Antos, Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute
Jennifer Bryant, Vice President, The Lewin Group
Juliette Cubanski, Senior Policy Analyst, Kaiser Family Foundation
Larry Grimaldi, Chief of Information and Public Relations, Rhode Island Department of Elderly Affairs
Julie James, Independent Consultant
Don Muse, President, Muse & Associates
John Richardson, Director of Medicare Practice, Avalere Health
Grace Marie Turner, President, Galen Institute
Jim Wilson, President, Wilson Health Information, LLC

Professional Associations

American Medical Association
American Pharmacists' Association
America's Health Plan
Association of Managed Care Pharmacy
BIO
Pharmaceutical Research and Manufacturers of America
Visiting Nurse Association of America

Appendix F: Analysis of Newspaper Coverage: Additional Detail

This appendix offers additional detail on the methods and results of the analysis of newspaper coverage.

Description of Main Newspapers Examined

Community One was an urban county in a mid-sized city; Community One's main paper typically had 6 sections. Community Two was a small city, with the main newspaper typically had four sections. Community Three was a large city and had two papers; both newspapers typically had seven sections each. Community Four included two counties in a large urban metropolis, with two very large papers; one paper had seven sections and the other contained ten sections.

Description of Senior Publications Examined

Communities One and Three each published a newsletter designed towards the lives and wellbeing of seniors. Communities Two and Four did not have senior publications. Both senior publications were similar in scope (what they reported on) and nature (how they reported). In our analysis, we included publications classified as newspapers, such as those found in Communities One and Three. Community One's publication was published consistent with the calendar months, while the Community Three publication ran mid-month to mid-month; all were monthly publications. To maintain consistency between the main newspaper and senior publications analyses, we included the senior publication that included the end of the period month (so for the time period that ran December 2003 – April 2004, the final included paper was the April 15, 2004 – May 15, 2004). Two months newspapers were missing (one for each community: in Community One, December 2003 paper and Community Three, November 15, 2004 – December 15, 2004). As there was one missing newspaper from each community, we believed the existing discrepancy would be minor.

Analysis Methods

To analyze the articles for content and themes, we created a checklist consisting of the following areas:

- Where written (by local paper staff/community members or through AP/Wires)
- Target audience (general population and specific to seniors)
    - The definition of the target audience had one major characteristic, those defined as "specific to seniors" had stories purposely targeted to seniors/about seniors.
- Theme (news/business, political, educational, editorial/op-ed)
    - Definition of theme included where the article was published in the paper, if it described the program and tried to educate the reader, if it was an editorial on the program written from an individual's point of view, was a news/business piece that discussed the program, and/or political, where the article mentioned political programs, agenda, and/or elections.
- Tone of the article (positive, negative, neutral)
    - Tone was defined as implying the program had value, did not have value, or was neutral about the program.

- Topic (general health care, specific to the drug card and/or describes the program, politics, and/or state program).

In the theme and topic areas, the sub-topics under each area were not mutually exclusive, meaning that more than one box could be checked. Attributes coded included:

- When the article was published (during what time period):
  - Right after passage of the Medicare Modernization Act (December 2003 – April 2004).
  - During initial enrollment period of the drug card program (May – September 2004).
  - Between initial enrollment and final enrollment of the drug card program (October – December 2004).
  - During final enrollment of the drug card program (January – March 2005).
  - Post-final enrollment of the drug card program (April – September 2005).
- Whether the article described eligibility requirements and benefits of the drug card program.
- Whether the article included contact information. If so, if the contact information was specific to the community or Federal/general information.
- If the article included any comments on the website or 1-800-MEDICARE
- If the article was the same as one that appeared in another community case study area.
- If articles included similar technology, in that the article appeared to heavily borrow from a common underlying source.

Results

Exhibit F.1 Newspaper Coverage By Community		Total All Communities and Papers	Community 1	Community 2	Community 3		Community 4		Community 1	Community 3
			MN 1	MN 2	MN 3	MN 4	MN 5	MN 6	SP 1	SP 2
Total Number of articles		**133**	**26**	**14**	**10**	**6**	**15**	**25**	**16**	**21**
Time Period of Article Published	# Right after MMA Passage: 12/03-4/04	**40**	8	4	2	3	3	8	6	6
	# During Initial Enrollment: 5/04-9/04	**60**	15	7	3	1	4	13	6	11
	# Between Initial and Final Enrollment: 10/04-12/04	**11**	1	2	0	2	1	2	1	2
	# During Final Enrollment: 1/05-3/05	**13**	1	0	2	0	7	1	1	1
	# Post Enrollment: 4/05 - 9/05	**9**	1	1	3	0	0	1	2	1
Where written	# from Staff Writers	**114**	25	12	8	6	11	15	16	21
	# through AP/Wires	**19**	1	2	2	0	4	10	0	0
Target Audience	# for General Population	**81**	24	11	8	6	10	22	0	0
	# Specific to Seniors	**52**	2	3	2	0	5	3	16	21
Theme	# with News/Business Theme	**77**	16	8	7	5	4	19	8	10
	# with Political Theme	**32**	7	2	3	3	4	10	3	0
	# with Educational Theme	**50**	6	8	5	1	6	9	3	12
	# with Op-Ed/Editorial Theme	**39**	14	5	0	2	9	5	3	1
Tone	# with Positive Tone	**26**	5	4	4	1	3	2	2	5
	# with Neutral Tone	**78**	11	5	6	4	7	17	12	16
	# with Negative Tone	**29**	10	5	0	1	5	6	2	0
Topic	# General Health Care	**38**	6	1	5	2	5	7	8	4
	# Specific to the Drug Card	**95**	14	12	9	5	10	22	6	17
	# Providing Federal/General Contact Information	**61**	12	6	4	4	6	8	5	16
	# Providing State/Local Contact Information	**33**	7	4	1	1	5	5	5	5
	# with Website/Hotline Comments	**40**	7	5	5	2	7	10	3	1
	# Including Eligibility Requirements/Benefits	**73**	17	7	5	3	11	13	7	10
	# with Political Discussion	**28**	5	4	0	2	6	7	4	0
	# Describing State Program	**26**	6	4	2	1	3	6	3	1
# Articles Published in Another Community		**3**	1	1	0	0	0	1	0	0
# Articles with Similar Terminology		**23**	5	6	2	0	1	4	0	5

MN = Main Newspaper, SP = Senior Publication