

A REPORT FROM THE FORUM SESSION

Implementing the Medicare Prescription Drug Benefit: Continuing Challenges for States

Lee Partridge, *Consultant*

OVERVIEW — *This National Health Policy Forum Meeting Report provides an overview and discussion of a technical session that took place on July 12, 2005. The meeting was designed to re-visit issues discussed at a similar meeting in July 2004, which was intended to offer a state perspective on the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 and the new Medicare prescription drug benefit. This report provides an update on the implementation issues identified in 2004—including outreach, education and enrollment; coordination of care for individuals who are “dually eligible” for Medicare and Medicaid; and the cost burden of the new program on states—and highlights new issues that have since emerged. Observations and recommendations from the panel are also included.*

A REPORT FROM THE FORUM SESSION:

Implementing the Medicare Prescription Drug Benefit: Continuing Challenges for States

On January 1, 2006, the new Medicare prescription drug benefit will become available to 43 million Medicare beneficiaries. In order to access this new benefit, Medicare beneficiaries must first decide whether they want to enroll in the new program and then must elect the prescription drug plan they wish to join. This process will take place between November 2005 and May 2006. In addition, for an estimated one in three Medicare beneficiaries (14 million), Congress has authorized special financial assistance in the form of a federal low-income subsidy (LIS)¹ to help individuals with the cost of the new benefit. Congress also granted most of these beneficiaries a special benefit package that permits them to enjoy uninterrupted drug coverage with no gaps and only very modest co-payments.² Like their more affluent peers, beneficiaries receiving the LIS assistance must also elect which drug plan they wish to join, with the exception of individuals dually eligible for Medicare and Medicaid. Those who are already receiving drug benefits in a state Medicaid program (the “full benefit dual eligibles”) will be automatically assigned to a drug plan if they do not choose a plan on their own before January 1, 2006.

As of December 31, 2005, states will no longer be able to receive federal matching funds for prescription drug expenditures, which will officially end Medicaid prescription drug coverage for dual eligibles. If they choose, these beneficiaries will receive their medications through the Medicare program instead. Federal matching funds will continue to be available to states that elect to cover over-the-counter medications, as well as other prescription drugs, such as benzodiasipines, that are not covered under the Medicare benefit.

Implementation of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 poses a number of challenges for states. In July 2004 the National Health Policy Forum held a technical briefing session to identify and discuss those challenges. The discussion that day was subsequently summarized in a Forum report issued on August 31, 2004.³ At that early date, the full scope and nature of many implementation issues were unclear. The federal regulations had not yet been published, and the outreach and education campaigns that the Department of Health and Human Services and the Social Security

National Health Policy Forum
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2131 K Street NW, Suite 500
Washington DC 20037

202/872-1390
202/862-9837 [fax]
nhpf@gwu.edu [e-mail]
www.nhpf.org [web]

Judith Miller Jones
Director

Sally Coberly
Deputy Director

Monique Martineau
Publications Director

Project Managers

Judith D. Moore
Senior Fellow

Jennifer Ryan
Senior Research Associate

Administration (SSA) would launch were in formulation. States were just shaping their own proposals and budget estimates in preparation for state legislative sessions in the winter of 2005. Many of the state decisions were dependent on the outcome of the federal decision-making process. Consequently, on July 12, 2005, the Forum convened a second discussion to provide an update on MMA implementation and to highlight new issues that emerged in the interim.

By July 2005, many of the questions that were raised in July 2004 had been resolved. Some were, however, still open, and other new issues had surfaced. To revisit and discuss these new and still unresolved issues, the Forum invited three state Medicaid officials—Mike Fogarty from Oklahoma, Carol Herrmann from Alabama, and Carolyn Ingram from New Mexico—to participate in this follow-up technical session. They were joined by federal staff, consumer advocates, Medicaid experts and researchers, and the senior official of a health plan that currently enrolls both Medicare and Medicaid beneficiaries. The dialogue provided valuable insight into current activities and policy concerns from the state perspective. Like the 2004 meeting, the July 2005 session was deliberately limited in size in order to permit in-depth discussion; therefore, the principal issues raised are summarized in this report for the benefit of our wider audience. A list of all the Forum participants appears in the final section of this report (see Appendix 2).

The intent of this report is to provide a current perspective on the multiple opportunities and potential barriers involved in implementing the Medicare prescription drug benefit. It is hoped that the panelists' observations will provide a better understanding of these issues and inform state and federal officials about potential problems, so that efforts can be made to resolve them. The observations and recommendations are a summary of points made by participants during the technical session. As always, the National Health Policy Forum hopes that this material will inform the broader policy discussion and will be helpful to beneficiaries, advocates, researchers, and other stakeholders by providing them with a richer appreciation of the challenges ahead.

Three main areas of concern emerged during the discussion:

- The daunting challenge of reaching, educating and enrolling the potentially eligible LIS beneficiaries not currently enrolled in any state Medicaid or prescription drug assistance program.
- The need to ensure effective coordination of care among Medicaid, Medicare, and private plans with regard to the dual eligibles.
- The cost burden to the states of the new prescription drug benefit, including the equity of the “clawback” payment.

The details of these concerns are provided in this report.

EDUCATION, ENROLLMENT, AND OUTREACH

Participants commended the federal agencies' energetic efforts with regard to reaching out to and educating beneficiaries about the new program. The Social Security Administration has a massive targeted mailing effort underway, sending program information and application forms to over 15 million potential LIS beneficiaries. SSA has directed its field staff to take advantage of community forums, health fairs, and other venues where potential beneficiaries might gather in order to explain the new benefit. The Administration on Aging has provided new funding and training opportunities and has suggested educational materials for its state and local agency grantees. The 2006 edition of the *CMS Medicare and You* annual handbook, which will be mailed to each Medicare household in October 2005, has been revamped to focus on the prescription drug benefit.

The Social Security Administration (SSA) has a massive targeted mailing effort underway, sending program information and application forms to over 15 million potential LIS beneficiaries.

In addition, CMS has extensively upgraded its Web site and telephone assistance capacity and has dedicated staff to work with many professional medical provider organizations as well as advocacy groups to help those organizations inform their membership. Providers, especially the physicians, pharmacists, health plans, and long-term care professionals who currently serve dual eligibles, need to be educated about the changes.

States have also undertaken their own education activities, independent of the federal agencies. They have done special mailings, spoken at meetings of state and local chapters of provider organizations, and organized statewide implementation taskforces. No one underestimates the magnitude of this undertaking.

Medicare Plan Selection for Dual Eligibles

To minimize the impact of the change in Medicaid drug coverage for dual eligibles, the federal government has decided it will automatically enroll them in a drug plan in the fall of 2005. First, CMS will match Medicare enrollment data with state data (as of July 2005) for full benefit dual eligibles. CMS will use this information to develop a pool of beneficiaries who are not currently enrolled in a Medicare Advantage Plan. In late September 2005, after all the Medicare Prescription Drug Plan (PDP) contracts are final, CMS will autoenroll those beneficiaries (effective January 1, 2006) in a PDP that serves their region. Individuals who were already enrolled in a Medicare Advantage plan will be autoenrolled in that plan for their prescription drug coverage. Both beneficiaries and states will be notified of the plan assignments in late October 2005.

However, because the time frame for the autoenrollment and notification process is so short, session participants noted there is a real question about the ability of states, plans, and the federal agencies to share enrollment

information accurately and promptly to avoid confusion. If a beneficiary finds himself in a plan that is not his preferred choice, he or she may switch, but each party needs to know about this possibility, and the process that must be followed to complete this switch must be clearly communicated and understood.

Informing beneficiaries about their right to switch plans poses a special problem for Medicare beneficiaries who are already members of a Medicare Advantage health plan. Because all Medicare Advantage plans will offer a prescription drug benefit, the beneficiary's logical choice, and the one the plans hope they will make, is to elect to stay with their current MA plan. Should they elect another drug plan, however, the beneficiary will be disenrolled from the MA plan and put back in the Medicare fee-for-service market for all of their Medicare benefits. Plans are making special efforts to inform their members about this possibility and explain what action they must take to keep their current coverage.

One concern that was raised involves subsidization of the Medicare drug benefit monthly premium. The law authorizes a premium subsidy only up to the amount of the "regional LIS benchmark," which is the average cost in that region of a standard prescription drug benefit package. Patient advocates have expressed concern that this limitation might place some of the existing Medicare Advantage plans out of reach for some beneficiaries, including beneficiaries currently enrolled in those plans. The health plan representative on the panel allayed that concern, however, by reporting that most of the plans believe they will be able to offer at least one prescription drug package (many of the MA plans offer several Medicare benefit packages) that will meet the LIS benchmark requirement.

Outreach

One major task facing all the organizations involved in implementing the drug benefit is reaching the millions of individuals who are not currently enrolled in the Medicaid program as either a full benefit dual eligible or a Medicare Savings Program (MSP) beneficiary,⁴ but may be eligible for the new drug subsidy and enhanced drug benefit. These are the individuals whose incomes are below 150 percent of the federal poverty level (FPL) and who have assets in excess of a certain dollar amount (\$10,000 per individual or \$20,000 per couple, in 2005). Some of these potential beneficiaries are probably known to states because of enrollment in a state-funded pharmacy assistance program, where they exist, and states will encourage these individuals to apply for LIS assistance. Many, however, have never come forward to apply for any assistance and have proved a difficult population to reach.⁵

Panelists noted that their outreach concerns are heightened by the fact that a beneficiary's failure to choose a plan when first eligible can result in a financial penalty in the form of a higher monthly premium for individuals who enroll in a drug plan after the deadline of May 2006.⁶ Due to the

time constraints for educating and enrolling everyone—LIS beneficiaries and non-LIS beneficiaries—there is grave concern that potential LIS beneficiaries will not get the outreach and education needed. As one state official said, “This is the group that is most likely to have no help now to get needed drugs. They should be our first priority.”

MSP Versus LIS: Making Sense of the Rules

One of the major points of confusion for beneficiaries may be that the MSP and LIS programs have similar but not identical eligibility requirements. The MMA allows individuals to submit an application for the LIS through either the SSA or the state Medicaid eligibility office. If they apply through SSA, that agency will review the application and make the LIS program eligibility determination. In addition, SSA will forward limited information about the applicants to the state so that the Medicaid agency can screen them for possible MSP eligibility. Persons applying at a state Medicaid office will be screened for Medicaid and/or MSP eligibility, and, if eligible, will automatically be deemed eligible for the LIS. If found ineligible for Medicaid or an MSP, applicants will be encouraged to fill out the SSA’s LIS application form, which the state will forward to the SSA for decision.

The decision on whether a person receives the LIS could depend on their state of residence and on the agency through which he or she applies.

In most states, the eligibility requirements for a MSP are different from those being used by SSA for the LIS program, so persons found eligible for either the MSP or the LIS benefits may not necessarily qualify for the other. Although the majority of states have less restrictive eligibility rules for MSPs than the LIS requirements, in some states the MSP rules are stricter than those for the LIS.⁷ Federal regulations specify that persons meeting a state’s eligibility criteria for Medicaid or its MSP are also entitled to the full LIS. Thus, the decision on whether a person receives the LIS could depend on his or her state of residence and on the agency through which he or she applies. For example:

- **States with more restrictive MSP rules.** Arkansas, New Jersey, and Ohio use the supplemental security income (SSI) asset rules to determine eligibility for their MSPs; the LIS asset limit is higher. In states such as these, persons could be found ineligible for MSP but still qualify for the LIS.
- **State with less restrictive MSP rules.** In five states—Alabama, Arizona, Delaware, Mississippi, and Minnesota—there is no asset limit for the MSP program. In these states, persons found eligible for the MSP would automatically qualify for the LIS. Some states use rules different from those of the LIS program regarding countable income. Indiana, for example, excludes in-kind support and maintenance; the LIS rules do not.

Federal officials are encouraging potential beneficiaries to use the SSA process because it is designed to be streamlined and user-friendly and

can be done by telephone, internet, or direct mail, as well as in person. In the less restrictive states, however, applying through SSA under the LIS rules would result in a denial of LIS eligibility, whereas applying through the state Medicaid agency would result in LIS approval due to the federal deeming provisions. It is important that “helper” organizations, including state and federal staff, be knowledgeable about these differences as they craft their information and assistance efforts.

CARE COORDINATION

Full Medicaid benefit dual eligibles and, to a lesser degree, state MSP beneficiaries often have multiple medical conditions and take multiple medications. Many are on “maintenance regimens,” meaning they must take certain medications daily or weekly in order to avoid acute care episodes or maintain physical mobility. Session participants, therefore, raised a number of issues concerning possible barriers to the effective coordination of care, both during the transition from Medicaid to Medicare coverage and after the beneficiaries are successfully enrolled in a Medicare plan.

Transition Issues

Panelists identified a host of transition issues. First was the obvious concern about effective transition for dual eligibles from the Medicaid program to a Medicare drug plan, in order to minimize any disruption in care. Beneficiaries or their surrogates, their primary care providers, and their pharmacists need to know the exception and appeal process that can be used if the Medicare plan’s formulary does not include the drug the individual is currently taking. There must be a method for resolving mechanical problems, such as delays in receipt of the Medicare plan’s enrollment identification card and inability to refill a prescription. Finally, if the state has decided to cover drugs excluded from the Medicare benefit package, like benzodiazepines, beneficiaries and providers need to know of those decisions rather than assume these drugs will no longer be available to the beneficiary after January 1, 2006.

Sharing Drug Utilization Data

Meeting participants agreed that an overarching challenge will be to coordinate care among three different entities—Medicaid, Medicare, and private plans—in a manner that ensures beneficiaries’ timely access to appropriate care. A key element in effective care management is ready access to data regarding beneficiary drug utilization. Under the federal regulations, the drug plans must submit this information to CMS but are not required to share it with the states for dual eligibles, even though the state may be providing long-term or acute care coverage for many of these individuals. As a result, the state may be unaware of a significant change in a person’s condition. Conversely, if an individual is taking a

An overarching challenge will be to coordinate care among three different entities: Medicaid, Medicare, and private plans.

drug that is not covered under the Medicare plan but is covered under the state Medicaid program, there should be a route for that data to be shared with the Medicare plan and/or Medicare primary care provider in order to avoid adverse drug interactions.

Finally, participants observed that lack of access can also hamper state fraud and abuse efforts, as a potentially significant amount of data that would help flag aberrant provider or recipient patterns could be lost.

Integration with Medicare Advantage Special Needs Plans

The MMA authorized a new type of Medicare Advantage plan, the Special Needs Plan (SNP), which can directly target dual eligibles for enrollment. This new type of plan has the potential to improve care coordination between the Medicare and Medicaid programs. New Mexico, for example, is in the process of implementing mandatory enrollment of its dual eligibles in managed care. The state is keenly interested in the possibility of enrolling them in Medicare SNPs, because doing so would place the locus of care coordination among acute and long-term care, as well as prescription drugs, within the same entity. Panelists pointed out that the effectiveness of the new plans may be hampered by the fact that Medicare and Medicaid managed care providers operate under different federal and state rules, which can lead to inefficiencies and confusion.

NEW STATE COSTS

Dual eligibles already are a very expensive segment of any state Medicaid population. They constitute the majority of users of nursing home care and home- and community-based care. In addition, dual eligibles account for more than half of the total Medicaid drug expenditures in any year. Over one third of the dual eligibles are *under* age 65 and eligible because of permanent disability. Their drug costs can be especially high, often due to heavy use of antipsychotic medications. Analysis of 1999 state Medicaid drug expenditure data done by Mathematica Policy Research, Inc., showed that the average drug expenditure for the disabled dual eligible was almost 50 percent more than the average spent for dual eligibles aged 65 and over.⁸ Total Medicaid expenditures for dual eligibles in 1999 were \$8.6 billion.

The Clawback Requirement

As Congress debated extending prescription drug coverage to all Medicare beneficiaries, it questioned whether the states should enjoy a fiscal “windfall” if the burden of paying for drugs for dual eligibles moved entirely to the federal government. As a result, the MMA includes a provision that exacts a payment (known as the “clawback”) from the states for each dually eligible beneficiary enrolled in the new Medicare program. This raises serious fiscal and policy concerns for the states.

The clawback formula uses 2003 as its base year in computing the average per-state drug expenditure for the dual eligibles. In many states, policy changes adopted in 2002 or 2003 have reduced that average dollar amount below the 2003 level, especially if adjusted for inflation. Alabama, for example, has implemented a preferred drug list, a therapeutic alternative formulary, and other initiatives that have altered its spending and saved an estimated \$116 million since 2003. None of those savings will be reflected in computing Alabama's clawback payment. A similar pattern prevails in many other states, where the average inflation-adjusted per capita cost for a dual eligible in 2006 could be below that of 2003.⁹

Counting dual eligibles — The clawback requirement may have the unintended consequence of discouraging states from expanding or continuing optional full Medicaid benefit coverage for seniors and disabled persons whose incomes fall between the mandatory coverage level and 100 percent of the FPL. That perverse incentive exists because another factor in the clawback formula will be the state's current enrollment of dual eligibles. If a state that today offers full Medicaid eligibility up to 100 percent of the FPL elects to roll back that income ceiling or eliminate the option altogether, it will reduce the current enrollment of dual eligibles and, therefore, its total clawback payment. Two states, Mississippi and Missouri, have passed legislation that would do that. Several other states discussed the possibility during their 2005 legislative sessions. Fiscal pressures may force more states into a similar posture in coming years, causing many seniors and individuals with disabilities to lose access to Medicaid-funded services.

State panelists also observed that there are likely to be problems determining exactly who is and who is not a dual eligible, or even a current MSP enrollee. The accuracy will depend on the data matches between state and federal files. Previous state-federal matches have frequently revealed multiple problems, such as beneficiaries with several Medicare identification numbers over time, beneficiaries with differing Medicare ID numbers on the state and federal files, and beneficiaries identified as Medicare recipients on a state or federal file, but not both (see text box).

Dual Eligibles: A Case Study

In an analysis done in Maryland using fiscal year 2004 data on approximately 120,000 dual eligibles, the findings indicated a variety of inconsistencies. Although nearly 90 percent of the files were successfully matched, a significant number of dual eligibles were not appropriately counted. For example, CMS had Medicare IDs for a large number of Medicaid enrollees that the state had not identified as dually eligible. Conversely, Maryland identified dual eligibles and has records showing the payment of Medicare Part B premium payments to CMS on behalf of more than 1,000 beneficiaries for whom CMS had no record in their Medicare files. In some cases, beneficiaries were identified on both files, but their Medicare ID numbers did not match.

There are numerous state and national implications from this example. First, only those dual eligibles that are identified on the state's file will be autoenrolled in the Medicare prescription drug benefit. Second, the clawback payments will be calculated from inaccurate files, and states will continue to pay incorrectly for prescription drugs (and other Medicaid services) for many individuals who are dual eligibles but have not been identified as such. Finally, it appears that Maryland has been paying some form of Medicare cost sharing for individuals who are not actually on Medicare. State and federal officials are already working to try to improve the data matches, but reconciling differences can often take considerable staff time and effort, resources that are in short supply at both the state and federal levels.

State panelists urged further discussion with their federal partners not only on the clawback formula itself but on the broader issue of whether this state payment to the federal government is an appropriate policy as currently configured.

The Woodwork Effect and Other Challenges

States will face, and are already incurring, other new costs due to the new Medicare drug benefit. They must be prepared to handle a surge in eligibility applications for both the LIS and MSPs. They must educate beneficiaries and providers about the Medicaid change. They will need to reprogram their claims payment, third-party liability, and eligibility management information systems. Most critical of all, they must expect and budget for increased caseloads in their Medicaid and MSPs if the outreach efforts are successful. Alabama, for example, estimates that its MSP caseload will grow by 30 percent.

The total new costs for the states could be considerable. Some argue that the MMA will result in savings in state health care costs for their retirees, but state officials noted that often those savings will accrue to the pension funds themselves and will not be available to a state's general fund or its Medicaid program. Thus the savings may not help close the gap between states' current Medicaid budget projections and their anticipated increased funding needs due to the Medicare drug benefit.

The MMA may result in savings to retirees, but those savings will likely accrue to the pension funds, not to a state's general fund or its Medicaid program.

OBSERVATIONS AND RECOMMENDATIONS

Over the course of the discussion, several key recommendations emerged for implementation of the new Medicare drug benefit, as well as post-implementation activities. Although not all participants concurred on every recommendation, each point listed below garnered support from at least two panel members at the meeting.

- **Delay the transition for dual eligibles.** To minimize potential disruptions in care and access to prescription medications for this vulnerable population, the group recommended postponing the December 31, 2005, termination date for federal Medicaid prescription drug coverage. Autoenrollment efforts could proceed, but the inevitable problems that will surface during the transition would not impact continuing drug regimens if federal Medicaid matching funds continued to be available for some limited period of time.
- **Postpone imposition of the late enrollment penalty.** The Medicare Modernization Act should be amended so that the late enrollment penalty for the LIS population will be postponed beyond May 2006. Outreach to the potentially eligible beneficiaries not currently known to the states or federal government through Medicaid and

MSPs is probably the greatest enrollment challenge; many individuals with incomes between 120 and 150 percent of the FPL, in particular, will be missed. A delay would allow the federal agencies, states, and community groups to focus on educating this vulnerable population after the bulk of the Medicare beneficiary population has made its plan decisions. In addition, these beneficiaries would not be penalized for their late enrollment.

- **Make drug utilization data available to states.** CMS should establish some mechanism that permits states' continued access to the Medicare drug utilization data. This would not only help improve the coordination of care for duals but also bolster state efforts to control fraud and abuse.
- **Streamline managed care coordination.** The different and sometimes conflicting regulations governing Medicaid managed care plans and Medicare Advantage plans should be reviewed with the intent of minimizing the resulting inefficiencies and confusion. This is particularly true for the policies governing the new Medicare SNPs that are intended to provide more integrated care for dual eligibles.
- **Revisit the clawback requirement.** Because a number of states implemented cost containment measures in fiscal year 2003 but did not realize Medicaid savings until fiscal years 2004 or 2005, the choice of 2003 as the baseline year adds to the cost burden on states. In addition, the clawback payment requirement may have the unintended consequence of acting as a disincentive for states to exercise the option of providing full Medicaid benefits to aged and disabled individuals with incomes up to 100 percent of the FPL.

ENDNOTES

1. The Centers for Medicare & Medicaid Services uses the term "limited income subsidy" when referring to this provision.
2. Beneficiaries with incomes below 100 percent of the federal poverty level (FPL) will have no monthly premium, no annual deductible, limited co-payments, and no "donut hole"—the gap in coverage when drug costs exceed a certain annual figure. Persons with incomes between 100 and 135 percent of the FPL have the same benefit package but slightly higher co-payments. Those with incomes between 135 and 150 percent of the FPL are entitled to a partial premium subsidy and are not subject to the donut hole, but must pay an annual deductible and 15 percent of drug costs up to an annual figure. Eligible nursing home residents will receive the full premium subsidy and will not be subject to the donut hole or the annual deductibles and co-payments.
3. See Judith D. Moore and Jennifer Ryan, "Implementing the New Medicare Drug Benefit: Challenges and Opportunities for States," National Health Policy Forum, Meeting Report, August 31, 2004; available at [www.nhpf.org/pdfs_other/MMAMtgRpt\(07-22-04\).pdf](http://www.nhpf.org/pdfs_other/MMAMtgRpt(07-22-04).pdf).
4. A Medicare Savings Program is one of the three benefits currently available to limited income Medicare beneficiaries who do not qualify for full Medicaid benefits in their state. The Qualified Medicare Beneficiary (QMB) program is open to persons with incomes up to

Endnotes / continued ►

Endnotes / continued

100 percent of the FPL; Medicaid will pay their Part B premium, Part A premium (if any), and Medicare deductibles and co-payments. The Specified Low Income Medicare Beneficiary (SLMB) program reaches individuals with incomes between 100 and 120 percent of the FPL; Medicaid pays only the Part B deductible for them. Both the QMB and SLMB programs are entitlement programs, meaning the state must enroll all applicants who meet the income and assets tests. The third program is the Qualifying Individual (QI) program, available to Medicare beneficiaries with incomes between 120 and 135 percent of the FPL. Under this program the state pays a portion of the Part B premium on behalf of the beneficiary. States can cap enrollment in the QI program.

5. The drug discount card program was also authorized under the MMA for 2004 and 2005 has even easier requirements to qualify for cash assistance in paying for prescription drugs. But despite vigorous federal, state, and advocacy group efforts, the program has yielded a disappointingly low enrollment rate.

6. Late enrollees will pay a higher premium of 1 percent per month of delay. For those with incomes below 135 percent of the FPL, the federal government will partially subsidize the penalty's cost.

7. Both LIS and state MSP eligibility criteria begin with the SSI eligibility rules. The LIS rules then deviate somewhat, principally through higher asset ceilings. State rules can vary with regard to both income and assets. See the June 2005 CMS state-by-state comparison of state MSP and SSI eligibility rules for more information, available at www.cms.hhs.gov/medicarereform/states/msp_charts.pdf.

8. See James M. Verdier and Myong Kim, "Medicaid Drug Use Data Show High Costs and Wide Variation for Dual Eligibles," Mathematica Policy Research, Inc., Issue Brief, Number 5, August 2005; available at www.mathematica-mpr.com/publications/PDFs/medicaiddata.pdf.

9. The clawback payments for 2006 are based on state prescription drug expenditures per full dual eligible for 2003, adjusted by the estimated average annual percent change in national per capita prescription drug expenditures for 2004, 2005, and 2006, including both Medicaid and private prescription drug expenditures. This growth factor will capture both Medicaid and private-sector cost and utilization trends between 2003 and 2006, not just Medicaid-specific or state-specific trends.



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**APPENDIX 1 — Agenda for July 12, 2005 Meeting
“Implementing the New Medicare Drug Benefit: Continuing Challenges for States”**

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- 10:00 am Welcome
Judith D. Moore, *Senior Fellow*, National Health Policy Forum
-
- 10:15 am OVERVIEW OF DUAL ELIGIBLES AND RELATED BENEFICIARIES
James M. Verdier, JD, *Senior Fellow*, Mathematica Policy Research, Inc.
- STATUS REPORT FROM STATES
Carol A. Herrmann, *Commissioner*, Alabama State Medicaid Agency
Carolyn Ingram, *Director, Medical Assistance Division*, New Mexico
Department of Human Services
Michael Fogarty, JD, *Chief Executive Officer*, Oklahoma Health Care Authority
- FEDERAL PERSPECTIVE
Gale Arden, *Director, Disabled and Elderly Health Programs Group*, Center for Medicaid
and State Operations, Centers for Medicare & Medicaid Services
- HEALTH PLAN AND BENEFICIARY PERSPECTIVE
Karen Davenport, *Washington Director*, Medicare Rights Center
Katherine H. Metzger, *Director, Medicare and Medicaid Programs*,
Fallon Community Health Plan
-
- 11:00 am A CLOSER LOOK
All Panelists
- Eligibility, outreach and process issues
 - Enrollment issues
 - Care management issues
-
- 12:30 pm Lunch
-
- 1:15 pm OTHER MAJOR CHALLENGES: MESHING DATA SYSTEMS AND STATE FINANCING ISSUES
Charles Milligan, JD, *Executive Director*, Center for Health Program Development and
Management, University of Maryland, Baltimore County
All Panelists
-
- 2:00 pm WRAP-UP AND CLOSING COMMENTS
Judith D. Moore
All Panelists
-

APPENDIX 2 — Expert Panelists and Meeting Participants

Expert Panelists

Gale Arden

*Director, Disabled and Elderly
Health Programs Group
Center for Medicaid and
State Operations
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services*

Karen Davenport

*Washington Director
Medicare Rights Center*

Michael Fogarty, JD

*Chief Executive Officer
Oklahoma Health Care Authority*

Carol A. Herrmann

*Commissioner
Alabama Medicaid Agency*

Carolyn Ingram

*Director, Medical Assistance Division
New Mexico Department of
Human Services*

Katherine H. Metzger

*Director, Medicare and
Medicaid Programs
Fallon Community Health Plan*

Charles Milligan, JD

*Executive Director
Center for Health Program
Development and Management
University of Maryland,
Baltimore County*

Lee Partridge

Consultant

James M. Verdier, JD

*Senior Fellow
Mathematica Policy Research, Inc.*

Meeting Participants

Rhoda Abrams

*Associate Adjunct Professor
Johns Hopkins University*

Melissa Atkinson

*Health Policy Advisor (R)
Senate Committee on Finance*

Melanie Bella

*Vice President for Policy
Center for Health Care
Strategies, Inc.*

Linda Bilheimer

*Associate Director, Analysis and
Epidemiology
National Center for Health Statistics
Centers for Disease Control
and Prevention
Department of Health and
Human Services*

Shawn Bishop

*Professional Staff Member (D)
Committee on Finance
U.S. Senate*

Charlene Brown

*Deputy Chief of Operations
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services*

Jim Cantwell

*Budget Analyst (R)
Committee on the Budget
U.S. House of Representatives*

Joy Chang

*Fellow
Office of Sen. Blanche Lincoln
U.S. Senate*

Jeanne De Sa

*Budget Analyst
Health Cost Estimates Unit
U.S. Congressional Budget Office*

Alissa Debo

*Special Assistant
Center for Beneficiary Choices
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services*

Colin Dixon

*Legislative Correspondent
Office of Sen. Patty Murray
U.S. Senate*

Sean Donohue

*Senior Policy Advisor
Office of Sen. James Jeffords
U.S. Senate*

Meeting Participants / continued ►

APPENDIX 2 — Meeting Participants (continued)

Deirdre Duzor

Co-Director
Medicaid Pharmacy Team
Center for Medicaid and State
Operations
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Lisa Dwyer

Health Scientist
Division of Health Care Statistics
Centers for Disease Control
and Prevention

Eugenia Edwards

Legislative Clerk (R)
Committee on Energy and
Commerce
U.S. House of Representatives

Ruth Ernst

Assistant Counsel
Office of the Senate
Legislative Counsel

Donna Folkemer

Group Director
Forum for State Health
Policy Leadership
National Conference of
State Legislatures

John Goetcheus

Assistant Counsel
Office of the Senate
Legislative Counsel

Vicki Gottlich

Attorney
Center for Medicare Advocacy

Ginni Hain

*Director, Division of Eligibility,
Enrollment, and Outreach*
Disabled and Elderly
Health Programs Group
Center for Medicaid and
State Operations
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Suzanne Hassett

Policy Coordinator
Office of the Secretary
Department of Health and
Human Services

Elisabeth Henderson

Intern
Medicare Rights Center

Janetta King

Senior Legislative Assistant
Office of Rep. Ted Strickland
U.S. House of Representatives

Brendan Krause

Senior Health Policy Analyst
National Governors Association

Kate Massey

Program Examiner
Health Division
Office of Management and Budget

Tom Miller

Senior Health Economist (R)
Joint Economic Committee

Peter Nalli

Intern
Office of Rep. Tom Allen
U.S. House of Representatives

Jennifer O'Sullivan

Specialist in Social Legislation
Domestic Social Policy Division
Congressional Research Service
Library of Congress

Erin Oldfield

Intern
Office of Sen. Patty Murray
U.S. Senate

Mara Patashnik

Office of Sen. Patty Murray
U.S. Senate

Richard Rimkunas

*Section Head, Income Support
Research & Development*
Domestic Social Policy Division
Congressional Research Service
Library of Congress

Sue Rohan

*Director, Hearings and Policy
Presentations*
Office of Legislation
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Matt Salo

Director
Health and Human Services
Committee
National Governors Association

Katie Simons

Health Insurance Specialist
Office of Legislation - Medicaid
Analysis Group
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

JoBeth Tananbaum

Intern
Office of Sen. Hillary Rodham Clinton
U.S. Senate

Karen Tritz

Analyst in Social Legislation
Domestic Social Policy Division
Congressional Research Service
Library of Congress

Alice Weiss

Health Counsel (D)
Committee on Finance
U.S. Senate