
NHPF Meeting Report

August 31, 2004

**NATIONAL
HEALTH
POLICY
FORUM**

A REPORT FROM THE FORUM SESSION:

Implementing the New Medicare Drug Benefit: Challenges and Opportunities for States

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INTRODUCTION

The National Health Policy Forum convened a meeting on July 22, 2004 to discuss state-based challenges associated with implementing the new Medicare drug benefit. The meeting brought together an extremely insightful and experienced group of current and former state officials and other experts to discuss key issues. In keeping with its tradition of promoting a frank, off-the-record exchange on health policy issues, NHPF does not normally prepare written summaries or reports of meetings. However, because this meeting provided vivid illustrations of the importance of state-federal collaboration for the successful implementation of the new drug benefit under Part D of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), participants agreed that the information should be shared more widely. Thus, this report is intended to provide a candid montage of the July 22 meeting and supply additional information and insights into state issues surrounding MMA implementation. An agenda for the meeting, as well as a list of participants, is attached to this report (Appendix C).

The meeting was structured as a facilitated but informal dialog designed to identify and clarify issues and to promote problem solving. The intent was to encourage the maximum participation of state experts on both Medicaid and pharmacy assistance programs while also providing an opportunity for a small audience of about 60 participants to ask questions and offer comments. This was a difficult undertaking in the time allotted, but the meeting provided some significant insights that the Forum hopes will be taken up in future discussions and activities.

Though the MMA offers a huge number and range of potential subjects, the discussion was focused around four primary areas: eligibility, enrollment, and outreach; the transition for dual eligibles; financing challenges; and administrative and systems issues. Each of these areas is discussed briefly below. The final section of this report contains a list of summary observations from the meeting.

This report is not meant to provide extensive details or to define issues as legislative, regulatory, state, or federal, and the Forum does not intend to use this publication to propose specific recommendations or solutions to problems. Rather, the objective is to provide a general understanding of the problems expressed by state experts so that more attention will be directed to these problems by appropriate officials at both the state and federal level. (It should be noted that the Notice of Proposed Rule Making (NPRM), or draft regulation, governing the implementation of the MMA was released by CMS just a few days after the meeting. A few of the issues discussed at the Forum session were somewhat clarified in that NPRM; however, most issues still require additional consideration and clarification.) As always, NHPF hopes to assist beneficiaries, advocates, researchers, and other MMA stakeholders by providing a sharper understanding of the difficulties faced by states as the new Medicare drug benefit becomes available in January 2006.

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BACKGROUND

When the new prescription drug benefit is implemented in 2006, it will make drug coverage available for the first time to all Medicare beneficiaries. Some of these beneficiaries are now covered by retiree health benefits, supplemental Medigap plans, and Medicaid or other state-funded programs, but at least 13 million seniors—nearly 40 percent of Medicare beneficiaries—have a major gap in health coverage and are required to pay out-of-pocket for the entire cost of their prescription drugs.¹ States have responded to this gap in coverage primarily through Medicaid programs and through the creation of state pharmacy assistance programs (SPAPs).

State Medicaid programs provide comprehensive prescription drug coverage for 6 million low-income elderly and disabled Medicare beneficiaries. Known as “dual eligibles,” these individuals rely heavily on the Medicaid program to provide the services that Medicare does not cover. (See Appendix A for more information on dual eligibles.) Although drugs are an optional Medicaid service, all states have provided a prescription drug benefit to eligible Medicaid beneficiaries for many years. Therefore, Medicaid has, until now, effectively filled this gap in Medicare prescription drug coverage for dual eligibles. In addition, many states have separately funded and established SPAPs to cover a portion of drug expenses for other low-income people who do not receive Medicaid. In 29 states, SPAPs provide subsidies and discounts to elderly and, in many cases, disabled individuals with a wider range of incomes.² The new Medicare drug benefit presents a myriad of potential new challenges and many major changes for those low-income people who already have drug coverage through Medicaid or an SPAP, as well as the states that have been serving them.

ELIGIBILITY, ENROLLMENT, AND OUTREACH

Beginning in January 2006, the MMA requires that all individuals who are eligible for both Medicare and Medicaid begin receiving their prescription drugs through the Medicare Part D program. This change will result in a significant shift in benefits for elderly and disabled dual eligible beneficiaries because they will receive their drugs through a prescription drug plan (PDP) rather than through the state. States have primary responsibility for determining eligibility and enrolling individuals in their Medicaid programs, and the MMA requires that states continue that responsibility in implementing a new “low-income subsidy” program that will be available under Part D. The statute and proposed regulation also require the Social Security Administration (SSA) to be available to make eligibility determinations for the low-income subsidies, but they do not specify how or what the interaction with states should be. (See Appendix B for specific information about the low-income subsidy programs.)

The creation of the low-income subsidy program, designed to assist dual eligibles and other low-income individuals with the cost-sharing requirements associated with the Medicare drug benefit, will have a

Medicaid has, until now, effectively filled this gap in prescription drug coverage for dual eligibles.

major impact on states. Individuals can apply for the subsidy either through the state Medicaid agency or through SSA.

While the income eligibility requirements for the subsidies (up to 150 percent of the federal poverty level, which was \$13,965 for an individual in 2004) are very similar to those currently used in Medicaid programs, the MMA includes a new asset test requirement. Asset tests are designed to take into account an individual's savings and other investments when determining eligibility. The new asset tests (ranging from \$6,000 to \$10,000 for individuals and \$9,000 to \$20,000 for couples) are more generous than those used by most states in Medicaid programs, which will add an additional layer of complexity for states attempting to facilitate enrollment for these individuals. In addition, SPAPs generally have not used asset tests, so (a) extra effort will be required in assisting SPAP enrollees in the transition to Medicare and (b) some SPAP-eligible individuals will not qualify for a low-income subsidy program because they have too many assets.

Despite these challenges, the first order of business for states will be to identify low-income people who are eligible for the MMA drug benefit, determine processes to enroll these eligibles, and develop education, information, and outreach programs so that beneficiaries will learn of and become informed about the new benefit. Among the most important eligibility, enrollment, and outreach issues discussed on July 22 are the following:

■ **The responsibility for eligibility determinations under MMA is assigned to both states and SSA.** Not only is there a potential for confusion, overlap, and duplication of effort between these entities, the lack of existing state-SSA communications and complementary information systems present major roadblocks. The fact that nearly half of the states—including large states like New York, New Jersey, California, and Ohio—involve or require counties to make eligibility determinations, enroll eligible people, and provide outreach and education, further complicates this problem. SPAPs, often found in large states with long-standing programs, face similar concerns.

■ **The asset test required by MMA will be different than those used currently by most states, and there is no clear crosswalk from the old to the new asset test for beneficiaries.** At a time when the trend has been for states to simplify their Medicaid eligibility and enrollment procedures and move to self-declaration of income or assets, the MMA asset test reinstates some old complexities, creating barriers to enrollment. State representatives voiced particular concerns about how many “gray areas” there are in applying asset tests, including, for example, the valuing of many types of life insurance, vehicles such as snowmobiles, and other items not clearly specified in the statute. The proposed regulation attempts to clarify this definition, asserting that only “liquid” assets, such as bank accounts, stocks, and bonds that can be converted to cash within 20 days (as well as real estate that is not considered the primary residence) will be counted, but complications will still abound.

Asset tests are designed to take into account an individual's savings and other investments when determining eligibility.

■ **The new MMA drug benefit is optional.** That is, beneficiaries must make a positive declaration and choice to enroll in the program, as well choose a Medicare Advantage (MA) plan or PDP drug provider. In addition, individuals who do not choose to enroll during the initial enrollment period will be required to pay a penalty in addition to the premium when they do enroll. While the concept of “choice” is important, for many dual eligibles and others now served by state programs (particularly those who have cognitive or severe medical problems) these features will likely complicate the outreach, eligibility, and enrollment process. Although automatic enrollment³ could facilitate these choices for many individuals, concerns about ensuring that these individuals are adequately represented remain.

■ **Intermittent eligibility in Medicaid programs may further complicate the transition to Part D and disrupt access to prescription drugs.** Unique Medicaid “spend down” or “medically needy”⁴ programs operate in 39 states. These programs allow people with high medical costs, including nursing home residents, to qualify for Medicaid by spending their income and resources down to a state-defined medical assistance eligibility level. In many cases, an individual may begin a month with a pension check or other source of income that makes them ineligible for Medicaid for the first part of the month, but once that income is put toward the cost of their care (that is, spent down), they become eligible for the remainder of the month. Depending on the spend down period designed by the state, individuals can cycle on and off of Medicaid eligibility as often as a monthly basis. This intermittent eligibility will significantly complicate the initial education and enrollment process and must be factored in to continuing administrative and policy decisions for states, the federal government, and providers of prescription drug benefits.

■ **The need for clarity around the use of auto-enrollment processes and the ability of state Medicaid and/or SPAP programs to “wrap around” the Part D benefit was stressed by all state officials.** The NPRM suggests that auto-enrollment will be available for those “full benefit dual eligibles” who are transitioning to the Medicare drug benefit, in hopes of making the process seamless for these particularly vulnerable beneficiaries. However, CMS has also indicated that it does not have authority to auto-enroll individuals who are currently enrolled in Medicaid Savings Programs (not considered full benefit dual eligibles). These individuals, also commonly referred to as QMBs, SLMBs, and QIs receive assistance through Medicaid with Medicare cost sharing but do not receive full Medicaid benefits (see Appendix A for further explanation). The use of auto-enrollment, a technique many states have used successfully in their Medicaid managed care plans, is seen as an important potential administrative tool by states. However, language in the proposed regulation has caused some confusion in this area and has generated significant debate among beneficiary and state advocates.

Depending on the spend down period designed by the state, individuals can cycle on and off of Medicaid eligibility as often as monthly.

■ **Some seniors have avoided programs for which they qualify because of the stigma they perceive to be associated with state Medicaid eligibility processes.** In fact, some SPAP programs were set up with this very concern in mind. Other beneficiaries, however, have become accustomed to dealing with specific state or county workers and may not understand that they do not have to change their existing relationships. Particularly in the early days of outreach and enrollment, the potential for confusion, duplication, and frustration for beneficiaries, states, and SSA will be high. These issues could be further complicated for individuals who reside for part of the year outside the state that is their primary residence, particularly if they happen to be at their secondary residence during the open enrollment period. Clear information for beneficiaries about where to go for assistance must be reflected in national, state, and local educational efforts. In addition, streamlining and standardizing applications and verification procedures will be critical in ensuring that all Medicare beneficiaries receive the same treatment.

■ **Education, information, and outreach efforts and responsibilities will be spread among a large number of state, federal, private provider, and advocacy organizations.** Because each state will be different in terms of its organization, structure, laws, and requirements, a uniform national effort will be difficult. Coordination will be a particular challenge.

THE TRANSITION FOR DUAL ELIGIBLES

Beyond eligibility, enrollment, and outreach, there are other specific concerns related to serving dual eligible people who are currently receiving drugs through their state's Medicaid program. Elderly and disabled beneficiaries who are dually eligible for both Medicare and Medicaid are among the most frail, vulnerable, and ill people in the country. Known for their high cost and complex health needs, many live in nursing homes and have cognitive impairments and multiple medical problems, all conditions that can limit their ability to live independently and make informed choices. Finally, there are major differences between elderly Medicare beneficiaries and Medicare beneficiaries who are eligible because of a disability. These two groups of people have distinct problems and should not be lumped together in the design of programs to assist them. Thus, managing the transition for dual eligibles will be particularly risky when the new Medicare drug benefit begins and disrupts existing processes for accessing prescription drugs. A number of very important issues surfaced at the July 22 session, including:

■ **For those residing in nursing homes, questions related to eligibility and enrollment, along with the "optional" nature of the Part D benefit and the requirements for choice, must be addressed.** In many nursing facilities, Medicaid prescription drugs are provided by large, specialized institutional pharmacies and paid for directly by the

The potential for confusion, duplication, and frustration for beneficiaries, states, and SSA will be high.

Medicaid agency, not by the nursing facility. Medicaid nursing facility residents are not accustomed to choosing the source of their prescription drugs. Who will provide outreach, education and enrollment services in nursing homes? Should a special enrollment process be developed for this population? Who has the authority to act on behalf of these vulnerable beneficiaries? Should special safeguards be employed in designing systems for this group?

■ **The adequacy of the Part D formularies offered to dual eligibles will be a key concern.** The MMA provides flexibility for PDPs and MA plans to decide which drugs will be covered and which will be limited or excluded. Therefore, it is possible, or even likely, that many plans' formularies will be less comprehensive than what Medicaid has provided. States' grievance and appeals systems will also be critical to this population if certain drugs are not available under a formulary.

■ **Administrative techniques to distribute drugs to dual eligibles will change and could negatively impact both providers and beneficiaries.** Because nursing homes utilize a different distribution channel for prescription drugs, often involving entities other than traditional PBMs, the transition to the new benefit will be complicated for residents of nursing facilities. The new drug distribution channels could also be restrictive for individuals currently receiving home and community-based services through Medicaid. For example, in the commercial insurance world, the delivery of maintenance medications for chronic illnesses is increasingly moving to a mandatory mail-order arrangement. Though more cost effective by far, this approach could be problematic for individuals requiring an institutional level of care.

■ **For both MA plans and PDPs, the potential for adverse selection if a large number of dual eligibles enrolls in the plan will be a significant concern.** Similarly, there is a concern that vendors might devise strategies to avoid enrolling dual eligibles, for fear of adverse selection. It is not clear at this point whether CMS payment rates for MA plans and PDPs will be adequately justified to reflect this risk.

■ **Care coordination and transitions for dual eligibles, while always difficult, will become even more complex.** The potential addition of new care managers could easily lead to significant overlaps and duplication of effort. For example, a dual eligible might be managed by his or her MA or PDP plan while living at home, but if that individual then had to be hospitalized, all the drugs would be included in the per diem or DRG (diagnosis-related group) payment at the hospital. And if that person further had to be moved to a nursing facility, the drugs and the care could be managed and provided by another Medicare plan as well as by the Medicaid agency. States expressed concerns about transitions for people when they are clearly not well and probably have limited capacity to make sound choices. The communication and financing challenges are daunting.

■ **Medicare and Medicaid data about this special population has never been efficiently (if at all) shared among and between CMS and the states.** The transition to the new drug benefit further hinders states' ability to track drug usage and expenditures for dual eligibles. In addition, drug files are often the only source of information Medicaid agencies have about disease prevalence in a population. The transition also raises questions about how and whether they will be able to get access to this information in a timely fashion in order to serve dual eligibles and to try to keep these beneficiaries in optimum health and with maximum functionality.

■ **Medicaid now provides a significant amount of over-the-counter drug coverage to dual eligibles.** Although states may continue to do so after Medicare takes over prescription benefits, it is not clear that the incentives will support this decision. In addition, there are questions about how or whether Medicaid will provide wrap-around coverage for prescription drugs that may not be available to dual eligibles through Part D (see sidebar).

Mental Health: A Case Study

Participants on July 22 discussed mental health issues and the unique situation that might exist for patients with severe and persistent mental illness, as a kind of case study under the general rubric of dual eligibles. This population, usually eligible for Medicare and Medicaid under the disability qualification because of a mental health diagnosis, can lead productive lives if their treatment—including prescription drugs—is appropriate and adequate. However, providing such care involves a great number of people and significant expense. A review of Medicaid data in one state indicated, for example, that 10 percent of all schizophrenics are dual eligibles, representing 25 percent of the total service and pharmacy costs of duals.* These significant costs heighten concerns about serving those in this population.

Effective treatment of severe mental illness usually requires access to appropriate psychotropic drugs, the newer of which, as noted, are often quite costly. Even if older drugs are classified in the same therapeutic category, most are not clinically interchangeable. The new system of competitive plans and distinctive closed formularies could adversely affect the availability of these drugs. And transitioning mentally ill patients from one medication to another, which could be necessary under the competitive drug plan and formulary system, is a difficult and complex clinical task that could have significant impacts on the quality and effectiveness of patient care.

For mentally ill people, access to the right treatment can mean clinical stability, ability to function in the community, and reduced overall cost of health care. Severely mentally ill patients can maintain normal functioning with appropriate drugs and care. Without it, they may have to be hospitalized. Concerns noted in "The Transition for Dual Eligibles" section of this report about grievance and appeals systems, as well as adverse selection, are particularly relevant for patients with mental illness who rely on particular psychotropic drugs.

**Comprehensive Neuroscience, Inc., and the Missouri Office of Medicaid, "Missouri Medicaid Data Analysis of Dual Eligible Beneficiaries," unpublished data, July 2004.*

FINANCING CHALLENGES

The MMA has a number of financial implications for states, primarily related to Medicaid. Perhaps the largest change will affect states both monetarily and on a broader, philosophical level regarding the state-federal Medicaid partnership. The “phased-down state contribution,” more commonly known as “the clawback,” creates for the first time a flow of funds *from* states back *to* the federal government. The clawback was created in the MMA conference committee discussions to help provide adequate funding for the new Medicare drug benefit. Beginning in FY 2006, states will be required to make a monthly payment to the federal government to, in effect, re-direct the money that the states would have spent on providing prescription drugs to beneficiaries in Medicaid. The clawback will consist of a monthly calculation based on the combination of (a) the state’s per capita spending on prescription drugs in 2003, (b) the state Medicaid matching rate, (c) the number of dual eligibles residing in the state, and (d) a “phase-down percentage” of state savings to be returned to the federal government, beginning with 90 percent in 2006 and phasing down to 75 percent in 2015.⁵

The clawback was designed with the expectation that states would receive a fiscal windfall when a large portion of their Medicaid prescription drug costs shift to Medicare. However, the calculations associated with determining the clawback payments are fraught with technical and political complications.

State concerns around financial issues related to the new drug benefit are discussed below.

Technical Concerns

■ **The definition of 2003 as the base year for the clawback is a source of concern for states.** As the state budget crises continued, by 2003 most states were taking aggressive actions to control costs and many looked to drug utilization review and other administrative savings techniques as a means of keeping Medicaid drug spending in check. The savings that will be generated by these efforts will not be realized until at least 2004, thus the base numbers for 2003 will most likely be overstated for many states. In addition, the Medicaid federal and supplemental drug rebates from 2003 will not be reflected at the time the clawback calculation is made. In fact, the Congressional Budget Office’s estimate suggests that the majority of the net relief will come to states between 2010 and 2015.⁶

■ **Inadequate Medicaid administrative data systems will make the calculation of the clawback difficult for states.** In addition, the requirement for *monthly* payments to the federal government is a major departure from the existing quarterly reporting structures.

“The clawback” creates for the first time a flow of funds *from* states back *to* the federal government.

Policy Concerns

■ **The number of dual eligibles has a significant effect on states' Medicaid costs.** The number of dual eligibles in the state could go up or down with accompanying increases or decreases in overall state spending. It is expected that state outreach and education efforts will result in a "woodwork" effect in Medicaid. CMS suggests that 1 million additional dual eligibles will be enrolled nationwide. Because the clawback calculation is based on the number of dual eligibles who enroll in the Part D drug benefit, states may have an increased incentive to control costs in ways that could be detrimental to beneficiaries. Depending on the future economy, states could feel compelled to limit the number of duals by cutting back the number or types of optional Medicaid eligibility groups, limiting or cutting benefits (such as over-the-counter drugs), or by limiting state outreach efforts.

■ **States will have greatly reduced bargaining power under the drug rebate program after MMA is implemented.** States currently are the largest purchasers of many drugs in the United States and receive substantial rebates based on getting the "best price" as a large purchaser, either through the primary Medicaid drug rebate program or through supplemental programs they have negotiated. Because about half of current Medicaid drug expenditures are for dual eligibles, the MMA benefit will result in significantly reduced bargaining power for states as the purchasing for this group shifts to Medicare.

■ **More prosperous states that have historically offered more generous Medicaid coverage will be disproportionately affected by the clawback.** These states will continue to receive only the minimum 50 percent federal matching rate, but they will pay at higher rates under the clawback, despite the theoretical shift to federal funding of the prescription drug benefit.

■ **Positive effects of MMA on state finances relate to the states' role as employer and provider of retiree health benefits.** There is potential for a substantial offset to states in retiree health costs under the provisions of Part D. Another potential area for state savings is through the new specialized plans targeted at serving dual eligibles to integrate and better manage their drug and health costs under both Medicare and Medicaid.

The MMA benefit will result in significantly reduced bargaining power for states as the purchasing for this group shifts to Medicare.

ADMINISTRATIVE AND SYSTEMS ISSUES

Medicaid is structured as a federal-state partnership; the state's role is to provide day-to-day administration of the program within broad federal rules and guidelines. States develop procedures for determining eligibility, enrolling beneficiaries, contracting with or credentialing providers, and processing claims. They create information and reporting systems to manage their programs. These reporting and management systems are different in every state and exist within a unique political and administrative climate. They are governed by different administrative procedures

requirements, exist in different state government agencies, and have dissimilar relationships with other state health, welfare, and social service programs. The old saying, which applies to administration as well as policy aspects of the program, is "If you've seen one Medicaid program, you've seen one Medicaid program." Each state has distinct information systems and idiosyncratic state laws and regulations to govern Medicaid, pharmacy assistance, and related programs, as well as different relationships with CMS, SSA, and other federal agencies. Overlaying a new federal drug benefit on 51 jurisdictions and the territories will not be easily accomplished in an administrative sense. Among the concerns expressed in this regard by July 22 participants are the following:

■ **"It is already too late for state system changes."** Information technology systems will have to undergo major reconfigurations to support modified eligibility, enrollment, data, and financial requirements; in many states, the lead time on such major modifications is 18 to 24 months, putting the completion date for such changes after the January 2006 start date for the Part D benefit.

■ **Communications between and among systems and agencies will be key.** Included are state Medicaid, aging, welfare, disability, social services, pharmacy assistance and administrative agencies; county governments; federal CMS, SSA, and HHS agencies; and finally, private MA plans and PDPs that are not yet identified. This is a daunting task. Data sharing will be critical to a strong and effective quality assurance system, as well as for monitoring against potential fraud and abuse.

■ **State 2006 budget requests are already due for consideration in the 2005 state legislative sessions.** Medicaid and SPAP directors have little information on which to base requests for specific activities.

■ **The prescription drug component of states' managed care rates will have to be removed once Part D is implemented and recalculated for future rate negotiations.** In addition, states like New York that now include drugs—both prescription and over-the-counter—in nursing facility rates will need to modify and renegotiate them. This will be a difficult and time-consuming process for states that are often governed by strict state administrative procedure laws.

■ **Some optional services, such as the provision of nonemergency transportation to pick up and deliver prescription drugs, will no longer be eligible for federal Medicaid matching funds.** It seems unlikely that Part D benefits will include coverage for this type of service, and Medicaid will not be able to continue payment because prescription drugs will no longer be a Medicaid-covered service for many individuals.

■ **Training of state staff is a major concern.** This is particularly true with regard to eligibility and enrollment. Most state eligibility workers do not specialize; they handle workloads that include Temporary Assistance for Needy Families, food stamps, Medicaid, and sometimes a variety of other programs.

"If you've seen one Medicaid program, you've seen one Medicaid program."

■ **Tension between CMS and states is currently very high in areas of financial and programmatic interpretation.** States noted that this climate does not encourage the flexibility and good will that would maximize the chance of effective cooperation in implementing the Medicare drug benefit.

SUMMARY OBSERVATIONS

In addition to the specific issues and problems discussed on July 22, a few key ideas seemed to generate a consensus among the state experts during the day's dialogue. While this is not an exhaustive list, the items listed here represent ideas with compelling policy and administrative priority.

■ There is agreement that for many of the most frail and vulnerable low-income individuals, an automatic enrollment process that enrolls a maximum of eligible beneficiaries will be more likely to result in continuity of coverage, as well as administrative simplification and coordination. However, the auto-enrollment period may not be long enough. States expressed the concern that some beneficiaries might have difficulty gaining access to needed prescription drugs for the first three to six months of 2006.

■ The Medicare drug benefit results in new and additional responsibility for states at a time of financial crisis and revenue shortfalls across the country. Although most states will eventually see savings from Medicare Part D, those savings may be less than some observers believe. The calculation techniques may limit savings, and administrative costs will increase in almost all areas of Medicaid management. In addition, any significant savings will not be realized for several years, long after states will have invested funds in developing and executing new eligibility, enrollment, and outreach processes and making systems changes.

■ Techniques to provide optimum integration of clinical care and drug therapy will be critical to ensure high-quality and efficient service to the dual eligible population. Some particular groups, such as the severely mentally ill, will require close monitoring as the implementation process proceeds.

■ Specialized MA plans targeted toward low-income dual eligibles and others with severe or disabling chronic conditions could go a long way toward correcting the facets of the new program that will otherwise make it much more difficult and expensive to integrate care and provide disease management services to people with multiple chronic illnesses. The statute includes several chronic care improvement demonstrations, and states are hopeful that major commitments will be made to encourage the development of the demonstrations and new plans.

■ Education and marketing materials, as well as other publicly available explanations of the MMA changes, must consider the age, frailty, and language and cultural challenges of elderly and disabled people. In

addition, the very significant differences between the elderly and the disabled must be reflected in all materials and outreach. Education and information campaigns must be coordinated and consider the needs of those residing in nursing homes, and those being served in home and community-based programs.

■ It is important to keep in mind that Medicaid dual eligibles have a comprehensive drug benefit now. Would a delay in their transition to Medicare drug coverage be a worthwhile consideration, especially since states will not be receiving significant short term savings from Medicare because of the clawback? This could ensure that states and Part D plans have all the necessary data-sharing arrangements in place and that duals have been enrolled in a Part D plan with appropriate transitions and continuity of care.

ENDNOTES

1. "Fact Sheet: Medicare and Prescription Drugs," Kaiser Family Foundation, April 2003; available at www.kff.org/medicare/1583-06-index.cfm.
2. An additional nine states have enacted laws to initiate SPAPs but have not yet implemented them. For further information, see "The Basics: State Pharmacy Assistance Programs" available at www.nhpf.org/pdfs_basics/Basics_SPAPs.pdf.
3. Automatic enrollment, in this case, will be designed to facilitate a seamless transition from Medicaid to Medicare for dual eligibles, who are often frail and vulnerable individuals. If an individual does not choose a PDP within the allotted time period, he or she will be automatically enrolled in a PDP that offers basic prescription drug coverage, is in the PDP region where the individual resides, and has a monthly premium which does not exceed the Part D premium subsidy amount.
4. "Medically needy" is an optional eligibility category under which the state permits individuals to qualify for Medicaid by deducting the cost of the person's medical care from his or her monthly income when determining eligibility. This concept of "spending down" to Medicaid eligibility is often used for elderly or disabled individuals who reside in nursing facilities, assisted living, or other community-based settings and who have high medical and/or prescription drug expenses.
5. For more information on the clawback calculation, see Andy Schneider, "The Clawback: State Financing of Medicare Drug Coverage," The Kaiser Commission on Medicaid and the Uninsured, Washington, DC, June 2004; available at www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=39919.
6. Congressional Budget Office, "A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit," Washington, DC, July 2004, 31; available at www.cbo.gov/showdoc.cfm?index=5668&sequence=2#pt3.

APPENDIX A: Defining Dual Eligibles

The term “dual eligible”^a actually encompasses two groups of individuals who are served by both Medicare and Medicaid:

Full benefit dual eligibles are low-income elderly and disabled individuals who are categorically and financially eligible for the Medicaid program, as well as for Medicare. Therefore, they receive full benefits under each program, including long-term care and prescription drugs. Six million individuals qualify as full benefit dual eligibles.

An additional 1 million Medicare beneficiaries are enrolled in voluntary *Medicare Savings Programs (MSPs)*, which were designed to assist low-income elderly and disabled individuals with paying for Medicare cost sharing. This group of individuals does *not* receive full Medicaid benefits. MSP programs include:

- **Qualified Medicare Beneficiaries (QMBs)** — Incomes below 100 percent of the federal poverty level (FPL); Medicaid pays all Medicare cost sharing.
- **Specified Low-Income Medicare Beneficiaries (SLMBs)** — Incomes between 100 and 120 percent FPL; Medicaid pays Part B premium only.
- **Qualified Individuals (QIs)** — Incomes between 120 and 135 percent FPL; Medicaid pays Part B premiums only; subject to availability of state and/or federal funds.

^aFor more information on Medicare savings programs and dual eligibles and how they are defined, see “Dually Eligible for Medicare and Medicaid: Two for One or Double Jeopardy?” NHPF Issue Brief 794, September 30, 2003, available at www.nhpf.org/pdfs_ib/IB794_Duals_9-30-03.pdf.

APPENDIX B: Defining the Low-Income Subsidy

Subsidy Group	Assets Test	Premium	Deductible	Co-Pay ^c (generic/brand)	Above catastrophic limit? ^d
Full Benefit Duals ^e					
<100% FPL	N/A	None ^b	None ^b	\$1/\$3	
>100% FPL	N/A	None ^b	None ^b	\$2/\$5	No cost sharing
Below 135% FPL	\$6,000 individual \$9,000 couple	None ^b	None ^b	\$2/\$5	No cost sharing
135% – 150% FPL	\$10,000 individual \$20,000 couple	Sliding scale	\$50	None	Up to limit, 15% co-insurance ; above limit, \$2/\$5 co-pay

^aIndividuals who are not living in an institution. Institutionalized duals are exempt from all cost sharing.

^bNo premium is required if the individual selects a PDP whose premiums are less than or equal to an average cost plan.

^cCopayment amounts will be indexed based on inflation and per capita growth in Part D expenditures.

^dCatastrophic limit is defined as the point at which an individual has spent \$3,600 out of pocket on drugs.

APPENDIX C: Agenda and Attendance List

- 10:00 am Registration — Coffee available
- 10:30 am Welcome, Introductions, and Overview of Issues
Judith D. Moore, *Senior Fellow*, National Health Policy Forum
Jennifer Ryan, *Senior Research Associate*, National Health Policy Forum
- 11:00 am ELIGIBILITY AND ENROLLMENT: OUTREACH FOR 2006
Kathy Kuhmerker, *Deputy Commissioner*, New York Office of Medicaid Management
Kathleen Mason, *Assistant Commissioner*, New Jersey Department of Health and Senior Services
John Wren, *Aging Services Program Officer*, DHHS Administration on Aging
- 11:45 am DUAL ELIGIBLES: MANAGING THE TRANSITION AND CLINICAL CONCERNS
Mary Kennedy, *Medicaid Director*, Minnesota Department of Human Services
Tom Snedden, *Director*, Pennsylvania Pharmaceutical Assistance Contract for the Elderly
James Verdier, *Senior Fellow*, Mathematica Policy Research, Inc.
Case Example: Mental Health – Carol Alter, MD, *Executive Director*, Treatment Effectiveness Now (TEN)
- 12:30 pm Lunch
- 1:00 pm STATE FINANCING ISSUES: ASSESSING SAVINGS AND COSTS
Chuck Milligan, *Executive Director*, UMBC Center for Health Program Development and Management
Richard Figueroa, *Legislative Director*, California Department of Insurance
- 1:45 pm EVALUATING IMPACTS: RE-CAPPING ADMINISTRATIVE AND SYSTEMS CHALLENGES
Barbara Edwards, *Deputy Director*, Office of Ohio Health Plans, Department of Job and Family Services
All State Representatives
- 2:15 pm Wrap-up and Summary of Issues
- 2:30 pm Adjournment

(Appendix continued)

APPENDIX C, continued: Attendance List

State Experts

Carol Alter*Executive Director*

Treatment Effectiveness Now

Barbara Edwards*Deputy Director*Office of Ohio Health Plans
Ohio Department of Job and Family
Services**Richard Figueroa***Legislative Director*

California Department of Insurance

Mary Kennedy*Medicaid Director*

Minnesota Department of Human Services

Kathy Kuhmerker*Deputy Commissioner*Office of Medicaid Management
New York Department of Health**Kathleen Mason***Assistant Commissioner*Division of Senior Benefits and Utilization
Management
New Jersey Department of Health and
Senior Services**Chuck Milligan***Executive Director*Center for Health Program Development
and Management
University of Maryland Baltimore County**Matt Salo***Director*Health and Human Services Committee
National Governors Association**Tom Snedden***Director*Pharmaceutical Assistance Contract for the
Elderly
Pennsylvania Department of Aging**James Verdier***Senior Fellow*

Mathematica Policy Research, Inc.

John Wren*Aging Services Program Officer*Center for Planning and Policy
Development
DHHS Administration on Aging**Participants**

Kathryn Allen*Director*Medicaid & Private Health Insurance Issues
GAO**Cheryl Austein-Casnoff***Director, Division of State Children's Health
Insurance*Family and Children's Health Programs
Group
DHHS/CMS/CMSO**Cristina Boccuti***Analyst*

Medicare Payment Advisory Commission

Jennifer Boulanger*Director*Health Policy
Johnson & Johnson**Jeffrey Buck***Associate Director*Center for Mental Health Services
DHHS/SAMHSA**Alice Burton***Director*State Health Group
AcademyHealth**William Clark***Director*Division of State Program Research
DHHS/CMS/ORDI/REG

Participants (cont.)**Andrea Cohen**

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

Alissa Deboy

Special Assistant
Disabled and Elderly Health Programs
Group
DHHS/CMS/CMSO

Colette Desmarais

Health Policy Advisor (R)
Committee on Finance
U.S. Senate

Deirdre Duzor

Co-Director
Medicaid Pharmacy Team
DHHS/CMS/CMSO

Ryan Faden

Health Policy Associate
Policy and Government Affairs
American Public Human Services
Association

Kate Finnerty

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State of Delaware

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Beth Fuchs

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John Goetcheus

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Office of the Legislative Counsel
U.S. Senate

Jill Gotts

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Ginni Hain

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Office of the Secretary
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CMSO Pharmacy Team
DHHS/CMS

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Georgetown University

Julianne Howell

Legislative Fellow
Office of Sen. John Kerry
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Alexandra Huttinger

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Julie James

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DHHS/CMS

Brendan Krause

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National Governors Association

Susan Lazaroff

State Advocacy Officer
American Psychological Association

Jean LeMasurier

Director, Health Plan Purchasing
Health Plan Benefits Group
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Michelle Lim

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The George Washington University

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Ann McCormick

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Lisa McCormick Lavery

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NJ Policy Forums on Health & Medical Care

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U.S. Senate

Dave Michalik

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State of Delaware

Karen Nelson

Health Policy Director
Office of Rep. Henry Waxman
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National Partnership for Women & Families

Josh Phillips

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Office of the Administrator
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Katiuscia Potier

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Office of Health Policy
Center on Budget and Policy Priorities

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Medicare Payment Advisory Commission

Participants (cont.)

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Congressional Research Service**Darlene Shughart**PACE Program
Pennsylvania Department of Aging**Cynthia Smith***Economist*Office of the Actuary
DHHS/CMS**David Smith***Attorney*Office of the General Counsel
DHHS/OS/CMS**Mimi Toomey***Manager of the Eldercare Locator*
U.S. Administration on Aging**Karen Tritz***Analyst in Social Legislation*Domestic Social Policy Division
Congressional Research Service**Judith Wagner***Scholar in Residence*

Institute of Medicine

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DHHS/OS/OD**Johanna Willer***Health Policy Intern*Division of State Program Research
DHHS/CMS/ORDI/REG**Claudia Williams***Consultant*

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Lisa Wilson*Special Assistant*Center for Medicaid and State Operations
DHHS/CMS**Carolyn Yocom***Assistant Director*Health Care Issues
GAO**Phyllis Zucker***Director*Policy Coordination
DHHS/AHRQ