

A REPORT FROM THE FORUM SESSION

Complexity, Coordination, and Compromise: States and the Medicare Drug Benefit

(August 4, 2006)

Lee Partridge, *Consultant*

OVERVIEW — *This National Health Policy Forum meeting report reviews a technical session that took place on August 4, 2006. The invitation-only meeting was designed to discuss implementation issues related to the new Medicare drug benefit, with special consideration of state activities, problems, and concerns. This meeting followed similar ones sponsored by the Forum in 2004 and 2005 in which the state perspective was the primary focus of conversation. Participants, including current and former state Medicaid directors, other state officials and experts, federal officials, Medicare drug plan representatives, and beneficiary advocates, described their experiences during the implementation process and addressed continuing challenges. Key topics discussed and summarized in this report include better use and sharing of data and information technology, financial effects of the Medicare drug benefit on states, new roles for plans and states, and opportunities for enhancing communications and partnerships to better serve dual eligibles and other low-income beneficiaries.*

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After many months of debate and negotiation, Congress in late 2003 through the Medicare Modernization Act of 2003 (MMA) passed a long-sought expansion of Medicare benefits to include coverage of outpatient prescription drugs. The new program, which began January 1, 2006, represents an important step forward in providing seniors and disabled Medicare beneficiaries with a health care insurance package that more closely resembles other sources of health insurance. The new drug coverage is provided by private plans under contract with the Centers for Medicare & Medicaid Services (CMS), generally either through stand-alone prescription drug plan coverage or through comprehensive Medicare Advantage plans.

Congress authorized a special, richer benefit package and also assistance with the cost of drug plan premiums and co-payments for an estimated one in three Medicare beneficiaries whose incomes fall below 150 percent of the federal poverty level (FPL).¹ Beneficiaries enrolled in Medicare and receiving full Medicaid benefits (known as “dual eligibles”) are automatically enrolled in a prescription drug plan. Other beneficiaries with low-income and limited assets may apply for a low-income subsidy (LIS). If found eligible, they pay no monthly premium (beneficiaries whose incomes fall between 135 and 150 percent of the FPL pay a portion of the monthly premium, determined by a sliding scale). Most beneficiaries qualifying for the LIS also pay modest co-payments for each drug and are exempt from the gap in coverage (for prescription drug costs in excess of \$2,250 but less than \$5,100) known as the “donut hole.”

Federal Medicaid matching funds for Medicare-covered drugs for dual eligibles ended December 31, 2005, but state involvement in administering prescription drugs to elderly and disabled individuals has not ended. For every dual eligible enrolled in a Medicare drug plan, states are required to share in the cost of the duals’ Medicare coverage by paying the federal government a fixed monthly amount known as the “clawback.” Some states may realize savings as a result of the new Medicare benefit because they will incur lower costs in their state employee benefit retiree plans and/or state-funded pharmacy assistance programs.

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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 Manager
Judith D. Moore
Senior Fellow

In 2005, a majority of states also offered seniors some form of assistance in purchasing prescription drugs through a pharmacy assistance program. With the advent of the Medicare drug benefit, states needed to review the scope and eligibility criteria for their programs to consider possible state-federal overlaps. Even in states without state pharmacy assistance programs (SPAPs), the end of Medicaid-financed drug coverage posed major challenges for dual eligibles needing to make the transition into a Medicare prescription drug plan. Thus, the implementation of the new Medicare program has continued to be a critical issue for all states.

In July 2004, the National Health Policy Forum held a technical workshop to identify and discuss various implementation issues. That initial discussion was summarized in a Forum report issued on August 31, 2004.² A second Forum technical session on the implementation of the Medicare drug program from the state perspective took place a year later, in July 2005. By that time many of the questions raised in 2004 had been answered. The discussion at the 2005 Forum session showed, however, that significant challenges remained, particularly around outreach activities, data coordination, provider education, fiscal and administrative impact on the states, and assurance of a smooth transition to Medicare for beneficiaries. At the same time, participants noted that the availability of drug coverage for dual eligibles would require the two programs—Medicare and Medicaid—to establish closer working relationships in order to assure continuity and high quality of care for their joint beneficiaries. The discussion from the second workshop is summarized in the Forum report “Implementing the Medicare Prescription Drug Benefit: Continuing Challenges for States,” released on September 22, 2005.³

In August 2006, the Forum convened for a third time a panel of federal officials, state Medicaid directors, drug plan officers, advocates, and researchers to assess the Medicare drug program implementation efforts to date and air their thoughts for the future success of the drug program, again with particular emphasis on state responsibilities. The discussion fell into three parts: the experiences of the past year, remaining operational and policy challenges, and opportunities for enhancing the value of the new program for the beneficiary, particularly the low-income Medicare beneficiary. This report summarizes that discussion.

THE 2005–2006 EXPERIENCE

The Forum began the 2006 meeting with an opportunity for panelists to reflect on their experiences over the past year with implementation. Each state, federal, plan, and beneficiary representative had their own perspectives on both milestones and impediments. These reflections are summarized here.

State Perspective

As January 1, 2006, approached, it was clear that state officials feared dual eligibles would have difficulty negotiating the new system to obtain the drugs they had formerly received under Medicaid. At the Forum meeting, a representative from the National Council of State Legislatures opened with a brief national overview of state actions to address that issue. Some states took steps, either administrative or legislative, in the fall of 2005 to guard against lapses in coverage by offering some kind of short-term emergency assistance to dual eligibles who found themselves without access to needed prescription drugs. As the enrollment problems mounted shortly after January 1, 2006, many more states acted to protect these beneficiaries. Eventually 40 states had such a program in place.

In February 2006 the federal government moved to require the drug plans to extend transitional coverage of all necessary existing prescription drugs to all new enrollees from 30 days to 90 days. Once this requirement was in place and the initial problems with accuracy of the enrollee information were sorted out, the state emergency programs began to wind down. However, four states—California, Illinois, New York, and Washington—authorized the operation of some kind of state-funded assistance “gap” program for the entire year.⁴

States also re-evaluated the role of their SPAPs in light of the new federal benefit. Many policy analysts had expected these programs to dwindle or disappear entirely because Medicare was assuming drug coverage responsibility. Instead, most states decided their SPAP programs were still needed to provide a safety net for their lower-income enrollees. As of November 2006, 19 states were operating state-funded programs, either a redesigned SPAP or a new initiative, that provided some form of “wrap-around coverage” or cost subsidy for members enrolling in Medicare drug plans. Five other states had the authority to do so but the programs were not yet in place.⁵ Most of these states require SPAP beneficiaries to enroll in a Medicare plan, so the SPAP then acts as the back-up. The state support takes various forms, including covering deductibles, co-payments, and premiums, assisting non-LIS eligible beneficiaries with payment for drugs once the beneficiary reaches the donut hole, and covering products not on the plan formularies or drugs excluded by statute from Medicare coverage, such as benzodiazepines and certain over-the-counter medications.

Four state Medicaid directors related their specific experience with the implementation of the new Medicare program.

Alabama — Alabama has 88,000 dual eligibles, so reaching them all and explaining the new benefit was quite a challenge. The state aging agency took the lead and organized workshops across the state. They also encouraged all those potentially eligible for the LIS to apply, adopting the slogan “When in doubt, fill it out.” The Medicaid director and senior staff participated

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directly in beneficiary outreach and enrollment sessions and handled individual casework as well. They also spoke at workshops and other meetings with provider groups, especially physicians and pharmacists.

The first few weeks of 2006 did not go well in Alabama. Many dual eligibles found they had been automatically enrolled⁶ in a plan that did not cover all of their drugs and found that the pharmacy could not verify needed information about their LIS status. The community pharmacists in the state were especially helpful during this period, providing many hours of special assistance to dual eligibles having problems and even giving the beneficiaries their drugs while payment responsibility issues were sorted out. The state supported the pharmacists' efforts by providing temporary assistance to help them meet the cash flow difficulties they experienced due to the initial confusion.

As the state had expected, the intense outreach initiative around the Medicare drug benefit also identified many lower-income individuals who had not previously come forward to apply for one of the state's Medicare savings programs (MSPs).⁷ The MSP caseload increased about 10 percent in the first quarter of 2006 from the 2005 level. The staff believe many of these individuals had never applied for a MSP because they saw such assistance as "welfare," whereas the Medicare drug program was not so perceived.

District of Columbia — DC adopted what it calls "consumer-centered" planning. The Medicaid director worked with a broad coalition of provider and consumer advocacy organizations, as well as other District agencies, to prepare them for the coming changes and to share information about federal initiatives and decisions as they became available. The director also followed up on each CMS letter to dual eligibles with a separate letter with details pertinent to District residents. A variety of community outreach activities undertaken by the District included working with the mayor's religious advisor to arrange for staff to attend Sunday church services and speak briefly to congregations about the availability of the new Medicare program and describe what they needed to do to enroll in a plan.

As was true in Alabama, the auto-enrollment of dual eligibles did not work as smoothly as hoped. Many of these beneficiaries found themselves without a plan or in a plan that did not cover their particular drugs. In January, the District put an emergency "patch" program in place and paid drug claims for dual eligibles who were unable to access necessary drugs through a Medicare plan. The patch program was ultimately extended through June 2006 and helped 14,000 of the city's approximately 16,000 dual eligibles.

Perhaps most important of all its initiatives was the District's income eligibility expansion. The city used its authority to "disregard" portions of individuals' income in order to enroll them in an MSP. The District effectively expanded MSP eligibility to 150 percent of the FPL as of July 1, 2005,

the same ceiling as that for the Medicare drug LIS program. Because the city has a combined intake process for all financial assistance programs and because beneficiaries enrolled in an MSP are automatically deemed eligible for LIS, city eligibility staff could find potential LIS beneficiaries eligible for MSP assistance and avoid sending them to the Social Security Administration (SSA) to apply separately for the LIS program.

New Jersey — New Jersey serves 140,000 dual eligibles through Medicare and Medicaid. Thousands more lower-income Medicare beneficiaries have enrolled in its principal SPAP program called Pharmaceutical Assistance to the Aged and Disabled (PAAD), one of the oldest and most expansive SPAPs in the nation. The state has a long-standing practice of using its PAAD enrollment data as a tool to share information about other programs for which beneficiaries might qualify, such as MSPs. When Medicare drug program implementation began in late 2005, the state again used its PAAD drug utilization information files to contact each member, recommending Medicare plans that met the beneficiary's drug coverage needs and pharmacy preferences and offering assistance in enrolling the member in the plan he or she selected. This process helped avoid some of the problems that occurred in other states, where residents found themselves enrolled in a plan that did not cover all their drugs. Nevertheless the transition in New Jersey was not without problems; therefore, the state Medicaid agency honored many pharmacy claims by dual eligibles through March 2006.

New Jersey also revised its SPAP to provide assistance with Medicare drug premiums, co-pays, deductibles, and coverage in the donut hole gap for all its SPAP enrollees, not just for dual eligibles.

Like Alabama and the District of Columbia, New Jersey developed a cadre of staff to act as a speakers' bureau for outreach efforts and to be available to community and provider groups across the state. State officials also wrote special follow-up letters to beneficiaries who were sent letters from CMS to clarify any information specific to New Jersey residents.

Oklahoma — The transition period for dual eligibles in Oklahoma was reasonably smooth. The state Medicaid agency took several steps to try to minimize problems months in advance of the January implementation date. The agency formed a dedicated intragovernmental workgroup to coordinate state efforts; the workgroup met weekly to track progress and discuss new issues. The state developed an aggressive consumer outreach and provider education initiative, which included customer service training for all staff who might receive a call from a beneficiary. In addition, the state devoted extensive resources in the summer and fall of 2005 to work with CMS to minimize any data discrepancies between the federal and state agencies with regard to accuracy of information about dual eligibles. As in Alabama, the state's community pharmacists proved to be especially helpful in resolving beneficiary problems.

Federal Perspective

Federal CMS officials at the Forum meeting acknowledged that some facets of the implementation process continue to be extremely difficult. Despite the two-year lead time between MMA passage and January 1, 2006, the time frame was very tight and required the dedication of significant staff resources. The agency found it had serious holes in its staffing, particularly with respect to pharmacists. Data resources were stretched thin, and the 1-800-Medicare phone capacity proved inadequate for the volume of calls received. Regulations had to be drafted, comments reviewed, decisions made, and the regulations published in final form. CMS also had to act swiftly to evaluate the bids and execute the contracts for a much higher volume of plan applicants than expected in order to be ready for open season enrollment in the fall of 2005.

With respect to identifying dual eligibles, CMS is dependent on eligibility information supplied by the states. CMS and the states formed a workgroup to identify potential Medicare drug implementation problems, especially in this area of data exchange, and performed preliminary system testing in 2005. Despite these efforts, many problems surfaced in January. (In states such as Oklahoma and Michigan that had been able to make data “scrubbing” a priority in the fall of 2005, many fewer problems appeared.)

Data exchanges between SSA and CMS also proved difficult, especially with regard to timeliness, resulting in delays in getting accurate information out to the plans. By August, however, the dust seemed to have settled and program operations were going much more smoothly. Nevertheless CMS staff, including those in the regional offices, continue to spend significant time on individual casework with beneficiaries in order to help them access needed drugs. CMS officials noted that the agency has actually benefited significantly from this hands-on experience.

Beneficiary Perspective

A staff attorney with the D.C. Legal Aid Society provided meeting participants with a case study of Medicare program implementation from the beneficiary perspective. Immediately after January 1, she and her colleagues received many appeals for help from Medicare beneficiaries in the District of Columbia. People were bewildered by the multitude of choices—more than 40 different Medicare drug plans were available. The beneficiaries were swamped with literature from the plans and had difficulty sorting it all out. Literacy was a particular challenge.

Dual eligibles had difficulty selecting a plan. One of the key questions to the Legal Aid Society was whether a plan would waive any co-payment requirements, particularly because a significant number of these beneficiaries were taking multiple drugs. Loss of coverage for certain

CMS staff continue to spend significant time on individual casework with beneficiaries in order to help them access needed drugs.

over-the-counter medications, such as vitamins, which had been covered under Medicaid drug programs, was also a concern, especially for persons with HIV/AIDS.

CMS funds a State Health Insurance Assistance Program (SHIP) in each state to assist Medicare beneficiaries; special federal funding was made available to the SHIPs to help them meet the expected demand for drug program information and assistance. Nevertheless, in the District those resources were still very limited, as its SHIP has a total paid staff of three. The organization was overwhelmed by the volume of requests.

To help with all these problems, the Legal Aid Society organized weekend “clinics” and trained more than 50 volunteer lawyers from the community to help beneficiaries enroll in an appropriate plan and to troubleshoot problems. Although the requests for assistance have dropped significantly since the end of the initial enrollment period in May, requests persist, mostly for new MSP beneficiaries who were auto-enrolled in a plan that does not suit their needs or for those who need help navigating a plan formulary exception or appeal process.

Plan Perspective

Drug plan officials reported that they also experienced many initial problems due to lack of information or misinformation. In many cases, the beneficiary LIS status data they received from CMS was wrong or incomplete. Enrollees did not always understand what to do when a drug they were taking was no longer covered; at the end of the transition period many had not asked their doctor to change the prescription or assist them in making a formulary exception request. Some of those who were enrolled in a Medicare Advantage plan prior to January 1 for regular Medicare benefits did not understand that by signing up for a stand-alone PDP plan they would automatically be disenrolled from their Medicare Advantage plan; many wanted to switch back. Dual eligibles who took multiple drugs were subject to co-payment requirements for the first time, could not afford the multiple co-pays, and did not know where to turn.

Plan officials also observed that marketing to the dual eligible population is much more time consuming than expected, and their call centers were overwhelmed. Many plans had adjusted their outreach activities to reflect this need as they prepared for the fall 2006 open enrollment period. One plan official also reported that his plan now offers all new enrollees a voluntary review of the individual’s drug regimen. The plan will pay a pharmacist to sit down with the beneficiary and go through his or her drugs to identify possible contraindication issues and encourage switching to generics where appropriate. This is expected to help beneficiaries and physicians avoid denials when prescriptions need to be refilled.

CONTINUING CONCERNS

As one panelist observed, “the sky is no longer falling,” but there is room for lots of improvement. Following are the key issues that were identified.

Data, Data, Data

Every panelist, from all perspectives—federal, state, beneficiary, plan—pointed to data issues as the single most serious set of unresolved problems around Medicare drug plan implementation. The issues cited include:

- Some married couples use a single Social Security number. This inappropriate practice complicates matches with Medicaid files, because all beneficiaries in that system have their own identifier.
- Participants reported that corrected data files do not always stay corrected. For example, after states resolve mismatches with Social Security files, such as resolving date of birth, the match will work for next month but then the correction is “unfixed” by SSA in the Social Security files the following month.
- Information the plans receive regarding patient LIS status is often wrong or unclear. Because the benefits are different for the various LIS groups, the beneficiary will be charged incorrect premiums or co-pays if this data is incomplete or inaccurate. Worse, some beneficiaries will find an unexpected drop in their monthly Social Security check if a premium is improperly deducted.

Data flow between SSA, CMS, and the states is still too slow. CMS is responsible for transferring the information from SSA about LIS applicants and the adjudication of their status to the states. Under the statute, states are supposed to receive this “leads” data and use it to screen LIS applicants for possible eligibility for its MSPs. Although some LIS applications were adjudicated as far back as the fall of 2005, by August none of the leads data had been received by a state. CMS staff said it hoped the data would be available before the end of 2006.

- The CMS data systems are old and “much patched.” Adding the Medicare implementation tasks to the demands on the system has only compounded the problems. Participants observed that a new “real time” system and more standardization of data formats are badly needed. Until they can be achieved, state and federal staff resources will have to continue to be diverted to short-term fixes.

Outreach and Beneficiary Education Issues

Several panelists expressed apprehension about the fall 2006 open enrollment season for all Medicare beneficiaries. All expected some consolidation of available plans, causing enrolled individuals, including duals, to make new choices. These beneficiaries will likely need assistance in

reconsidering their options. The benefit structures and prices of some existing plans will undoubtedly change as well, further complicating the choices.

A special consideration for LIS beneficiaries is the fact that the federal subsidy only applies to monthly premiums in excess of a certain dollar figure, known as the “low-income benchmark.”⁸ If the premium of a LIS beneficiary’s current plan is above the low-income benchmark amount in his or her region, the beneficiary must pay the difference out of pocket or choose another plan. Panelists feared that the 2007 low-income benchmark amounts would fall below the 2007 premiums of many of the plans, precipitating multiple plan switches. In fact, that now appears unlikely, as the list of plans available for 2007 released by CMS at the end of September shows more plans available in most areas than was true in 2006. In addition, CMS exercised its demonstration authority to calculate the low-income benchmark figure for 2007 in a manner designed to minimize the number of plans with premiums above it. It thus appears that for 2007 only a small number of LIS beneficiaries will have to change plans.

Drug plans, pharmacies, and beneficiaries can be confused by differences between Medicare Part B and Medicare prescription drug coverage rules. One example cited is that of a cancer patient who requires anti-nausea medication. The drug is not covered by the Medicare drug plan he selected, but he is entitled to coverage for it under cancer-specific terms of his Part B package. It was suggested that CMS needs to give the plans, pharmacies, and the beneficiary case workers better guidance for this type of situation.

Several panelists observed they have a continuing concern that aggressive marketing by some plans may lead to fraud or identity theft because beneficiaries volunteer sensitive personal information in the application and plan selection process. Federal officials share that concern and noted that they are developing a fraud and abuse prevention plan that includes an extensive beneficiary education component.

Beneficiary representatives noted that people often do not realize a beneficiary found eligible for the LIS does not need to wait until the next open season to enroll in a plan. If SSA and CMS helped publicize that fact, the agencies could reduce the counseling burden. Beneficiary assistance organizations noted that it would be very helpful if state drug coverage information, such as SPAP wrap-around benefits, could be incorporated in the CMS PlanFinder data.

Participants also noted that community and advocacy organizations that have been an integral part of the Medicare drug benefit outreach and enrollment effort are now finding themselves overwhelmed with requests for assistance by Medicaid applicants and current enrollees who are trying to meet the proof-of-citizenship requirements Congress set forth in the Deficit Reduction Act of 2005. These demands will mean even fewer resources are available to help low-income beneficiaries and others in

the upcoming months. Panelists note this is a serious shortfall because a vigorous outreach effort must be maintained to reach the estimated four million beneficiaries eligible but still not enrolled, many of whom are also potentially eligible for the LIS as well.

Fiscal Impact on States

States continue to be concerned about the fiscal impact of the new drug benefit on state Medicaid budgets. These concerns include:

- Uncertainty about whether states will be able to negotiate satisfactory continuing Medicaid drug rebate agreements with drug manufacturers. The high-volume users of certain drugs are now covered under Medicare, not Medicaid, therefore states fear their bargaining power may be diluted.
- Belief on the part of a number of states that the “clawback” provision (the decision by Congress to require states to contribute to payment for the cost of transferring dual eligibles to Medicare for drug coverage) is unconstitutional. Five states, including New Jersey, asked the U.S. Supreme Court to hear their argument on this issue, but it refused their initial request. States expect to pursue the issue through the (more typical) route of U.S. District Court with any subsequent appeals to higher federal courts. The issue will continue to be a source of federal-state tension.
- Uncertainty about the effect the drug program will have on future Medicaid caseloads. As noted above, Alabama reported it had already seen a 10 percent increase in its MSP caseload as a result of the Medicare LIS outreach. Few other states have reported such escalation. Because none of the SSA leads data had yet reached the states, states that have not seen MSP growth fear it may still lie ahead, and that the necessary additional funding to accommodate that growth will not be included in the state’s budget.

The LIS Asset Test

Several panelists pointed out that the asset test for the LIS has proved to be a significant eligibility barrier for thousands of low-income Medicare beneficiaries. Raising the dollar amount, or eliminating the asset test altogether, would help many of these individuals get the prescription drugs they need. The asset test also penalizes those seniors who have been careful to save for their expenses in retirement. Because the asset test is a statutory requirement, Congress would have to act to make this change.

REALIZING THE PROGRAM’S PROMISE

Despite the multiple challenges that remain to make the Medicare prescription drug program work effectively for dual eligibles, panelists pointed

to several very positive achievements so far. These include policy and operational changes that enhance the opportunities for Medicare-Medicaid integration and new tools to monitor the quality of prescription drug management and provide beneficiaries with better information to guide future plan choices.

Maximizing Medicaid-Medicare Integration Opportunities

Participants at the 2005 version of this Forum meeting pointed to the new type of Medicare Advantage plan, the special needs plan (SNP),⁹ as a promising tool for improving care for dual beneficiaries. A SNP can offer its dual eligible enrollees a single locus for inpatient, outpatient, and prescription drug coverage, and, if it also contracts with the state Medicaid agency, access to the broader package of Medicaid services. However, participants at that meeting pointed out that the differing federal and state rules governing managed care entities might dampen a SNP's interest in contracting with both governments and thereby reduce the promise of this new coverage vehicle.

Since the July 2005 Forum meeting, state and federal officials, together with staff of the Center for Health Care Strategies and others, have made important strides to address overlapping or conflicting state-federal rules. On July 27, 2006, CMS announced an action plan to facilitate the integration of care for duals through SNPs. This action plan includes the release of three "how to" guides—for marketing, enrollment, and quality.¹⁰ CMS has also adopted a new policy that will allow SNPs to target enrollment of a subset of dual eligibles if the SNP also has a relationship with the state Medicaid agency. Federal outreach and beneficiary education materials for 2007 include information about the opportunities for integrated care available through SNP enrollment.

Sharing Drug Utilization Data

Progress has also been made on another aspect of Medicaid-Medicare integration, the sharing of utilization information between the programs. States historically have used drug utilization information about Medicaid beneficiaries as an integral part of their care coordination and quality improvement programs. It enables them, for example, to identify underutilization patterns for persons with chronic diseases, or to detect potential polypharmacy problems when a beneficiary consults multiple providers. Without an agreement among plans to share that data, state administrators would no longer have access to that beneficiary data when Medicare plans assumed the responsibility for prescription drug coverage. Data sharing is also critical in situations where a plan's Medicare prescription drug benefit overlaps Medicaid coverage and the Medicaid agency needs to know that the plan, not the Medicaid program, should be the primary payer.

Accordingly, the states enlisted federal assistance in making that data sharing possible, and suggested three specific steps: (i) establish a standardized data format for the Medicare prescription drug data; (ii) assure states they can claim the cost of upgrading their computer systems at the 90 percent federal matching rate so that the data could transfer seamlessly; and (iii) support use of a model data exchange agreement so that the states could continue to have drug utilization information about dual eligibles.

By the end of July, CMS had issued the 90 percent matching rate assurance and a standardized data format had been adopted. A model data exchange agreement was still being reviewed. Panelists reported that California had individual data exchange agreements in place with every Medicare drug plan in the state, and other states were looking to California as a potential model. This model has both pros and cons; the method it employs is incredibly burdensome for the state, but the model does ensure the necessary data exchange.

Improving Quality of Care

As noted above, Medicaid agencies for many years have been using prescription drug claims information to enhance the quality of care for Medicaid beneficiaries and to improve patient safety. Because Medicare did not previously cover prescription drugs, CMS was denied such opportunities. Now they are in a position do so.

The Department of Health and Human Services has also moved to develop quality measures for the prescription drug plans' performance. CMS formed a Prescription Drug Quality Alliance in the spring of 2006 to recommend a comprehensive set of measures by the end of the year. Meanwhile, CMS has begun to collect some simple metrics, such as call waiting times, etc., that it is posting on its Web site to help inform future beneficiary choices.

LOOKING AHEAD

As one participant observed, times of crisis such as the transition problems of January and February 2006 are also opportunities for learning. Indeed, the group agreed that much has been learned. In addition, panelists noted that the partnership efforts at all levels have worked for the most part, and will continue to be needed. Prompt, regular communication among all partners—federal agencies, states, plans, consumer organizations, and beneficiaries—is critical. Ongoing involvement of community organizations is key if beneficiary counseling is to be effective. Existing policies must be regularly re-evaluated to minimize barriers and to ensure program effectiveness in improving care. Above all, participants agreed, the new benefit will work best if all involved remember that the beneficiary must be the central focus.

The states enlisted federal assistance in making data sharing possible.

ENDNOTES

1. In 2006, 150 percent of the FPL for an individual was \$14,700; for a family of two, it was \$19,800.
2. 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).
3. See Lee Partridge, "Implementing the Medicare Prescription Drug Benefit: Continuing Challenges for States," National Health Policy Forum, Meeting Report, September 22, 2005; available at [www.nhpf.org/pdfs_other/MMAMtgRpt\(07-12-05\).pdf](http://www.nhpf.org/pdfs_other/MMAMtgRpt(07-12-05).pdf).
4. For much more detail on state actions, see National Council of State Legislatures (NCSL), "State Pharmaceutical Assistance Programs in 2006: Helping Make Medicare Part D Easier and More Affordable," updated November 2, 2006; available at www.ncsl.org/programs/health/SPAPCoordination.htm.
5. NCSL, *State Pharmaceutical Assistance Programs*, Issue Brief, updated November 28, 2006; available at www.ncsl.org/programs/health/drugaid.htm.
6. In order to minimize any gaps in coverage, CMS automatically enrolled dual eligibles in a prescription drug plan. Because CMS does not have beneficiary-specific information to determine whether a particular plan's formulary covered the enrollee's current drug regimen, the assignments had to be made on a random basis.
7. Medicare savings program is the term applied to any of three programs (QMB, SLMB, and QI) that offer low-income Medicare beneficiaries assistance with all or some portion of the cost of their Medicare Part B (outpatient) coverage. Eligible individuals must have incomes below 135 percent of the FPL but above the state's income threshold for full Medicaid benefits. The states receive federal matching funds for these programs.
8. For more information about the calculation of the low-income benchmarks, see Mary Ellen Stahlman, "A Closer Look at the Medicare Part D Low-Income Benchmark Premium: How Low Can It Go?" National Health Policy Forum, Issue Brief 813, August 2, 2006; available at www.nhpf.org/pdfs_ib/IB813_LowIncomeBenchmark_08-02-06.pdf.
9. SNPs were authorized by the MMA and are permitted to limit their enrollment to persons dually eligible for Medicaid and Medicare, residents of nursing facilities or similar institutions, and those who have severe or disabling chronic conditions.
10. The "how to" guides can be downloaded from the CMS Web site at www.cms.hhs.gov/DualEligible/04_IntegratedMedicareandMedicaidModels.asp#TopOfPage.



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**Appendix 1 — Agenda for the August 4, 2006 Meeting
“Complexity, Coordination, and Compromise: States and the Medicare Drug Benefit”**

9:00	Continental Breakfast
9:30	WELCOME AND INTRODUCTIONS Judy Moore , <i>Senior Fellow</i> , National Health Policy Forum
9:45	IMPLEMENTATION EXPERIENCES Expert Panelists Reflections by panelists on specific implementation issues over the past year to identify continuing challenges: <ul style="list-style-type: none">■ Reports from States■ Federal Perspectives■ Plan and Beneficiary Observations
11:30	DISCUSSION: ADDRESSING CHALLENGES AND NEXT STEPS Expert Panelists Beneficiary Issues: <ul style="list-style-type: none">■ Eligibility, Open Season Processes, and Choices for Beneficiaries■ Assisting Beneficiary Decision-Making
12:30	Lunch
1:00	ADDRESSING CHALLENGES AND NEXT STEPS – CONTINUED DISCUSSION Expert Panelists State Fiscal Issues: <ul style="list-style-type: none">■ Federal-State Data Sharing and Information Technology Issues■ Reaching the Unenrolled Low-Income Subsidy (LIS) Groups New Roles for Plans and States: <ul style="list-style-type: none">■ Potential for Special Needs Plans (SNPs)■ Medicaid/Medicare/Plan Partnerships
2:30	WRAP UP AND CLOSING COMMENTS Judy Moore Expert Panelists and Meeting Participants

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

Melanie Bella

Vice President
Policy
Center for Health Care
Strategies, Inc.

Richard Cauchi

Health Program Director
Pharmaceuticals Project
National Conference of State
Legislatures

Bob Donnelly

Vice President
Government Programs
MemberHealth

Charlene Frizzera

Deputy Chief Operating Officer
Office of the Administrator
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Carol Herrmann-Steckel

Commissioner
Alabama Medicaid Agency

Jack Hoadley, PhD

Research Professor
Health Policy Institute
Georgetown University

Joy Johnson Wilson

Health Policy Director
National Conference of State
Legislatures

Mary Kennedy

Vice President
State Public Policy
Evercare and Ovations

Ann Kohler

Director of Medicaid Program
State of New Jersey

Robert Maruca

Director of Medical Assistance
Medical Assistance
Administration
District of Columbia,
Department of Health

Chuck Milligan, JD

Executive Director
Center for Health Program
Development & Management
University of Maryland
Baltimore County

Lynn Mitchell, MD

Medicaid Director
Oklahoma Health
Care Authority

Lee Partridge

Health Policy Advisor
National Partnership for
Women & Families

William Scanlon, PhD

Consultant
National Health Policy Forum

Andy Schneider

Senior Advisor
Office of Health Policy
Center on Budget and
Policy Priorities

Sarah L. Spector

Staff Attorney
DC Legal Aid Society

James Verdier, JD

Senior Fellow
Mathematica Policy
Research, Inc.

Meeting Participants

Allison Barrett

Researcher Assistant/Programmer
Mathematica Policy
Research, Inc.

Shawn Bishop

Professional Staff Member (D)
Senate Committee on Finance

Jennifer Boulanger

Director
Health Policy
Johnson & Johnson

Meeting Participants / continued ►

APPENDIX 2 — Meeting Participants (continued)

William Clark

Director
Division of State
Program Research
Office of Research,
Development, and
Information
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Elise Desjardins

Program Associate
Grantmakers In Health

Sharon Donovan

Analyst
Center for Beneficiary Choices
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Michael Doonan

Director
Massachusetts Health
Policy Forum

Ruth Ernst

Assistant Counsel
Office of the Senate
Legislative Counsel

Anita Everett

Senior Medical Advisor
Center for Mental
Health Services
Substance Abuse and
Mental Health Services
Administration
Department of Health and
Human Services

Lynda Flowers

Senior Policy Advisor
Public Policy Institute
AARP

John Goetcheus

Assistant Counsel
Office of the Senate
Legislative Counsel

Vicki Gottlich

Attorney
Center for Medicare Advocacy

Suzanne Hassett

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

Rosa Campos Hernandez

*Vice President for Grants
and Operations*
Texas Institute for Health
Policy Research

Christine Hinds

Health Insurance Specialist
Medicare Drug Benefit Group
Center for Beneficiary Choices
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Kathy King

Director
Health Care Issues
Government Accountability
Office

Debra Lipson

Senior Researcher
Mathematica Policy
Research, Inc.

Samara Lorenz

Health Policy Analyst
Office of Planning and
Evaluation
Health Resources and
Services Administration
Department of Health and
Human Services

Kristina Lowell

Policy Analyst
Office of Policy
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Andrea Maresca

Health Policy Associate
National Association of State
Medicaid Directors
American Public Human
Services Association

Jim McLean

Vice President
Public Affairs
Kansas Health Institute

Camille Miller

*President and Chief
Executive Officer*
Texas Institute for Health
Policy Research

Patricia Nemore

Attorney
Center for Medicare Advocacy

Jennifer O'Sullivan

Specialist in Social Legislation
Domestic Social Policy Division
Congressional Research Service

Katie Pahner

Legislative Analyst
Office of Legislation
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Katharine Salter Pinneo

Co-Director
National User's Group
Planning Grant

Meeting Participants / continued ►

APPENDIX 2 — Meeting Participants *(continued)*

Susan Reinhard

Co-Director
Center for State Health Policy
Rutgers University

Sally Richardson

*Executive Director and Associate
VP Health Sciences*
West Virginia Institute for
Health Policy Research

Jason Robinson

Summer Intern
National Academy of
Social Insurance

Rachel Schmidt

Senior Analyst
Medicare Payment
Advisory Commission

Nina Schwartz

Legislative Correspondent
Office of Rep. Betty McCollum
U.S. House of Representatives

Karen Shore

Director
Center for Health Improvement

Vernon Smith

Principal
Health Management Associates

Jennifer Snow

Legislative Analyst
Office of Legislation
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Andrew Sperling

*Director of Federal
Legislative Advocacy*
National Alliance for the
Mentally Ill

Maria Tracy

Senior Health Policy Advisor
Disabled and Elderly Health
Programs Group
Center for Medicaid and
State Operations
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services

Karen Tritz

Specialist in Social Legislation
Domestic Social Policy Division
Congressional Research Service

Molly Voris

*Senior Policy Analyst,
Health Division*
Center for Best Practices
National Governors Association

Alan Weil

Executive Director
National Academy for State
Health Policy

Lisa Wilson

Health Insurance Specialist
Intergovernmental Affairs
Centers for Medicare &
Medicaid Services
Department of Health and
Human Services