Robert Wood Johnson Foundation

Published: February 10, 2009
Last Updated: October 15, 2009
Program Results Report
Grant ID: DEP

# State Solutions: An Initiative to Improve Enrollment in Medicare Savings Programs

An RWJF initiative

## SUMMARY

*State Solutions* was designed to increase enrollment in Medicare Savings Programs (MSPs). These programs, funded through Medicaid, help low-income Medicare beneficiaries with their out-of-pocket medical costs.

Beginning in July 2002, organizations in each of five states—Louisiana, Minnesota, New Hampshire, New York and Pennsylvania—received three-year grants of up to $420,000 to undertake initiatives to boost MSP enrollment. (By the time sites applied for *State Solutions* grants, the Commonwealth Fund had signed on to support Minnesota with a grant of $300,000.)

Staff and consultants at the national program office at the Rutgers Center for State Health Policy provided technical assistance and direction to the states as they implemented their plans. They also disseminated information to other state and federal policy-makers about innovative and promising practices for increasing enrollment in MSPs.

### Program Evolution

The passage of the Medicare prescription drug benefit, known as Medicare Part D, led *State Solutions* to shift its focus because of the overlap between potential beneficiaries of Part D's Low-Income Subsidy Program and the Medicare Savings Programs. *State Solutions* worked with state and national policy-makers to explore ways to share data and streamline outreach and enrollment into these programs.

### Key Results

- In the five grantee states, enrollment in the two largest Medicare Savings Programs increased from approximately 447,000 in August 2002 to 646,000 in November 2005, a 45 percent increase, compared with a 22 percent increase nationwide.
- The five grantee states used many approaches to identify and enroll new participants in Medicare Savings Programs. Strategies included modifying the programs' eligibility requirements, expanding outreach activities, simplifying the enrollment

process, training staff and volunteers to conduct enrollment activities, forging partnerships, expanding enrollment opportunities, strengthening data collection and engaging state representatives to explore barriers to enrollment.

- *State Solutions* informed state and federal policy initiatives designed to maximize enrollment in Medicare Savings Programs, according to the program director. For example, the Medicare Payment Advisory Commission, an independent congressional agency that advises the U.S. Congress on Medicare, used findings from *State Solutions* grantees to support its March 2008 recommendations to Congress.

## Key Recommendations

The following recommendations were made at a 2007 summit sponsored by the *State Solutions* national program office for state and federal policy-makers, private sector leaders and advocates:

- Simplify the administration of Medicare Savings Programs and the Part D Low-Income Subsidy program.
- Improve data sharing to ensure that beneficiaries are enrolled in the programs for which they are eligible.
- Engage the private sector more fully in efforts to enroll more beneficiaries.

## Key Conclusions

According to national program office staff:

- Outreach efforts were most successful when they were targeted specifically to individuals who met the Medicare Savings Programs' eligibility criteria and when they included specific information about how and where to get help.
- Program operations can be improved by efforts to understand the MSP application process from the perspective of its beneficiaries.
- Policy changes that simplified the application and renewal processes helped boost enrollment.
- The need persists to reach and enroll low-income Medicare beneficiaries in the Medicare Savings Programs, as well as in the Low-Income Subsidy program available under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Medicare Part D).

## Funding and Management

The Robert Wood Johnson Foundation (RWJF) Board of Trustees authorized *State Solutions* in October 2001 for up to $4 million.

Program staff at the Rutgers Center for State Health Policy in New Brunswick, N.J., administered the program and provided technical assistance and guidance to the grantee organizations in the five states.

## THE PROBLEM

Most elderly and disabled Americans receive basic health coverage through the Medicare program. Medicare does not cover all medical costs, however. Beneficiaries are responsible for paying premiums, co-payments and deductibles, as well as for services not covered by Medicare. These costs can be significant, imposing barriers to health care on people with limited incomes.

Medicare Savings Programs (MSPs) are designed to help Medicare recipients with limited income and resources cover some of these costs. Although some enrollees can save more than $2,000 per year, these programs have been undersubscribed throughout their history. Data sources differ somewhat, but according to Social Security Administration figures cited in 2004 by the Center for Medicare Education, about 40 percent of people eligible for the two most popular MSPs are not enrolled.

### Understanding the Different Programs

***Medicare*** is the U.S. government's health insurance program for people age 65 or older or those with specific disabilities or end-stage renal disease requiring dialysis or a transplant.

Currently available to about 40 million people, Medicare covers inpatient hospital stays, outpatient care and physician services.

The cost of prescription drugs has been subsidized for Medicare recipients since 2006, when the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Medicare Part D) was fully implemented. Unlike other parts of Medicare, Part D coverage is available to beneficiaries only when they enroll in one of the many hundreds of plans offered by private companies.

Part D includes a Low-Income Subsidy program (also known as "Extra Help") to provide eligible people with extra assistance with the cost of prescription drugs. Individuals who are eligible for the subsidy do not pay a Part D premium.

Medicare is funded by the Social Security Administration, with a budget roughly equal to 10 percent of the total U.S. budget. The Centers for Medicare & Medicaid Services (CMS) administers the program.

***Medicaid*** is administered by the states and provides public assistance to persons who meet certain income and resource criteria, regardless of age. The federal government,

through CMS, dictates a basic package of services that must be provided and shares costs with the states.

***Medicare Savings Programs*** are financed and administered through Medicaid for a subset of the Medicaid population. States are obliged to provide specific benefits to qualified individuals, primarily through three programs:

- **Qualified Medicare Beneficiary (QMB) program,** implemented in 1986, is an entitlement program for Medicare beneficiaries with incomes at or below 100 percent of the federal poverty level. Personal assets cannot exceed $4,000 for an individual or $6,000 for married couples, exclusive of home, car and a small burial fund. The QMB program covers the cost of Medicare premiums, deductibles and coinsurance for eligible individuals.
- **Specified Low-Income Medicare Beneficiary (SLMB) program,** implemented in 1993, is an entitlement program for individuals with incomes at least 100 percent but below 120 percent of the federal poverty level. Personal assets cannot exceed $4,000 for an individual or $6,000 for married couples, exclusive of home, car and a small burial fund. The SLMB program pays Medicare part B premiums (but not the deductibles or coinsurance).
- **Qualified Individual (QI) program,** implemented in 1998, is for individuals with incomes at least 120 percent but below 135 percent of the federal poverty level. There are no asset restrictions for eligibility. The QI program requires state Medicaid programs to pay all of the Medicare part B premiums (but not the deductibles or coinsurance).

  The QI Program is funded with $1.5 billion in federal dollars over a five-year period and is subject to annual reauthorization. Because the funding amount is fixed, eligible individuals receive assistance on a first-come, first-served basis, rather than as an entitlement available to all who meet the criteria. These benefits are not available to those who qualify for any other Medicaid program.

Income and asset eligibility criteria for all Medicare Savings Programs are current as of October 2008 and are subject to change every April.

States have no obligation to provide other Medicaid benefits to these populations. However, many states do offer other benefits to the low-income, Medicare-eligible population, including State Pharmaceutical Assistance Programs and programs specifically for persons with disabilities.

## Enrolling in MSP Programs

Individuals who are dually eligible for both Medicare and one of the MSPs (or for full Medicaid) are not automatically enrolled in an MSP; they must complete an application through Medicaid and document eligibility.

Both the federal and state governments have implemented strategies to identify dually eligible people and encourage them to enroll in MSPs. For example, the federal Department of Health and Human Services provides, to states that request them, lists of newly enrolled Medicare beneficiaries whose income from Social Security is less than 100 percent of the federal poverty level.

Known as "leads data," this information can be used for targeted outreach and enrollment activities, such as direct mailings to potential beneficiaries and cross-checking existing Medicaid rolls. However, leads data do not provide all of the information about an individual's income and assets that may be necessary to determine MSP eligibility.

### Barriers to Enrollment

According to studies conducted by the U.S. General Accounting Office (March 2004) and the Center for Medicare Education (2004), low enrollment in Medicare Savings Programs reflects:

- Lack of knowledge about the programs among those who might help people enroll (such as welfare workers, Social Security Administration employees and employees of community-based organizations).
- Ineffective outreach to people who may be eligible.
- A cumbersome eligibility determination and enrollment process that varies among state Medicaid programs and often requires long waits in welfare offices, face-to-face interviews and extensive documentation of income and assets.
- Difficulties with language and transportation.
- Concerns about the Medicaid estate recovery program, which allows states to recover the costs of nursing facilities and other long-term-care services from the estates of Medicaid beneficiaries.
- Perceived stigma among some potentially eligible beneficiaries about enrolling in a program for low-income people.

## CONTEXT

Since its inception, RWJF has supported a wide range of programs, research and communication campaigns to improve access to stable and affordable health care coverage, including:

- *Health Care for the Uninsured Program*, a $6 million initiative started in 1985 that encouraged small firms in 11 states to provide employer-sponsored health insurance to more employees. The grantees designed new insurance offerings and marketed them to small firms in their states.

- Increasing access to coverage through the national programs *Covering Kids* and *Covering Kids & Families*.
- Understanding costs and financing mechanisms through the national program *Changes in Health Care Financing and Organization*.
- Analyzing proposals to expand coverage through the *Covering America Project* with grants to the Economic & Social Research Institute (see Program Results on ID#s 037951 and 040946).
- Helping states plan and develop insurance market reforms to expand health coverage for the uninsured through the national program *State Initiatives in Health Care Reform*.
- Increasing awareness among policy-makers and action by the general public through *Cover the Uninsured Week*.
- The $51 million *State Coverage Initiatives*, launched in 1991 as State Initiatives in Health Care Reform and running until May 2011, is testing different strategies to expand coverage. The program works directly with state officials, helping them plan, execute and maintain health insurance expansions, as well as to improve the availability and affordability of health care coverage. (See this report for more detail about the program's enrollment activities.)
- *Communities in Charge: Financing and Delivering Health Care to the Uninsured* worked at the community level. This program, begun in 1997, worked with local communities to improve access to care for low-income, uninsured individuals by rethinking the organization and financing of local care delivery. (See *Anthology*, Vol. X and Program Results on *Communities in Charge*.)

*State Solutions* was unusual in that it targeted people who already had health insurance (Medicare) but were not getting the full benefit of other programs for which they were eligible. The program pursued a pragmatic approach to expanding coverage: help eligible adults enroll in supplemental Medicaid programs that cover Medicare premiums. Even though Medicare covers all Americans age 65 or older, its monthly premiums are out of reach for some low-income elders. These supplemental Medicaid programs fill the gap.

*State Solutions* was originally envisioned as a pilot program that would lead to an expanded national demonstration program. However, the expected expansion did not occur because of changes in leadership and strategy at RWJF.

## PROGRAM DESIGN

RWJF designed *State Solutions* to help states maximize enrollment in the various Medicare Savings Programs.

*State Solutions* earmarked some $2 million of the $4 million authorization for grants to state groups to implement strategies to increase enrollment. The program aimed to fund each of four grantees for up to $450,000 for three years and to add a fifth state if another funder supported the project. (By the time sites applied for *State Solutions* grants, the Commonwealth Fund had signed on to support a fifth state, Minnesota, with a grant of $300,000.)

The remaining $2 million would allow the national program office to provide technical assistance and direction to the grantee organizations, conduct research and inform policy-making.

## Two Types of Grantees

Two types of grantees were eligible for *State Solutions* grants:

- State Medicaid agencies, which could use grant funding to improve their Medicare Savings Program eligibility and enrollment policies and processes.
- Coalitions of public agencies, advocacy groups and health care providers, who could use grant funding to improve program policy, administration and enrollment through collaborative efforts. Although state agencies were required to be part of the coalition, they could not serve as the lead organization.

The program required grantees to provide 50 percent matching support through in-kind contributions and local grants.

## Project Goals

RWJF expected the state Medicaid agency grantees to improve their systems for determining eligibility and enrolling and retaining individuals entitled to both Medicare and some form of Medicare Savings Program benefits. Activities to support this goal could include analyzing enrollment data and identifying barriers, analyzing and improving the processes by which they worked and analyzing and changing policy.

Possible goals for coalition grantees included:

- Simplifying the enrollment and renewal processes for Medicare Savings Programs.
- Coordinating with existing programs serving the dually eligible population.
- Developing outreach strategies to increase awareness among eligible individuals.

## THE PROGRAM

### Management

In November 2001, RWJF established a national program office for *State Solutions* at the Rutgers Center for State Health Policy. The center is part of the Institute for Health, Health Care Policy and Aging Research at Rutgers, the State University of New Jersey, in New Brunswick, N.J. It was created and supported by RWJF (see Program Results ID# 034067) to inform, support and stimulate state health policy in New Jersey and around the nation.

The center's co-director, Susan C. Reinhard, R.N., Ph.D., served as national program director for *State Solutions* from November 2001 to October 2004. Marlene Walsh, M.P.A., served as deputy director during that period and succeeded Reinhard as director in November 2004.

In collaboration with RWJF, Reinhard established a seven-member national advisory committee of experts in the areas of Medicaid policy, health and aging and policy advocacy (see Appendix 1). The advisory committee members participated in the site selection process, made site visits and provided advice on various issues facing the grantees as they implemented their projects.

### Site Selection

In January 2002, *State Solutions* issued a call for proposals inviting groups to apply for grants of up to $450,000 over three years to implement strategies to increase enrollment in Medicare Savings Programs. Some 19 state agencies and coalition groups submitted applications.

In the spring of 2002, all 19 applicant groups met in Baltimore with *State Solutions* staff and with national advisory committee members for a "reverse site visit." This provided an opportunity for applicants to ask questions about the program and for staff and advisory committee members to assess each site's commitment and readiness. In July 2002, grant awards were made to agencies and organizations in Louisiana, Minnesota, New Hampshire, New York and Pennsylvania (see Project List). The Commonwealth Fund provided $300,000 in funding for the Minnesota project.

Two grants—to the Louisiana Department of Health and Hospitals and to the Minnesota Department of Human Services—went directly to the state Medicaid agencies that administer the Medicare Savings Programs. (See Louisiana Site Profile.)

In the three other states, grants went to coalitions of private and government groups. The lead agencies were:

- The Community Services Council of New Hampshire, a private, nonprofit organization that assists individuals and families in need. The organization operates vocational day programs, homeless services, residential services for people with disabilities and programs for adults with Alzheimer's disease or other memory impairments.

  The Community Services Council leads the New Hampshire Medicare Savings Coalition, a collaborative group that includes New Hampshire state officials, such as legislators and representatives of health, human service and aging agencies; university representatives; and provider and advocacy groups, such as New Hampshire Legal Assistance, New Hampshire Council of Churches and a senior center.

- The Medicare Rights Center in New York and Washington conducts enrollment projects to help people gain access to benefits, provides a free telephone hotline, educates people with Medicare and those who counsel them and works on Medicare reform efforts at the national level.

  The Medicare Rights Center leads the Medicare Savings Programs Coalition, which includes advocacy organizations, such as AARP and the Brookdale Center on Aging; private health insurance plans; and government officials from city and state departments of health and aging, among others.

- The Pennsylvania Health Law Project provides free legal services and advocacy to Pennsylvania residents having trouble gaining access to publicly funded health care coverage or services. The group's Pennsylvania Campaign for Affordable Health Care administered the *State Solutions* project.

  Participating members of that coalition include advocacy groups, such as Citizens for Consumer Justice and the Elderly Law Project of Community Legal Services; the Pennsylvania Departments of Aging and Public Welfare; and a health maintenance organization.

See Project List for contact information. See Key Site Activities and Results for information about the grantee projects.

## Program Evolution

### *RWJF Drops Plans for Formal Evaluation*

RWJF originally planned a formal evaluation of the program and funded researcher Carolyn Needleman, Ph.D., of the Bryn Mawr School of Social Work, to gather information from the grantee organizations and prepare a detailed proposal for the evaluation. However, when it became clear that *State Solutions* would not expand into a nationwide program, RWJF staff decided not to pursue a formal evaluation. Instead, *State*

*Solutions* worked with a core group of researchers to prepare reports and articles exploring the experiences of the state projects (see the Bibliography).

### *Implementing the Medicare Part D Prescription Benefit*

Passage of the Medicare Part D prescription benefit, and its Low-Income Subsidy program, significantly altered the emphasis of the *State Solutions* national program office activities.

After the legislation was signed into law in 2003, the Centers for Medicare & Medicaid Services had a relatively short time to plan for its implementation in January 2006. During that period, CMS and the states had to:

- Plan for the coverage of people eligible for both the Medicare Part D subsidy program and Medicaid.
- Decide on the process for determining eligibility and the income and asset tests that would be required for the subsidy.
- Address a number of other issues that could affect those enrolled in MSPs.

When the legislation was passed, it was unclear how the requirements of the Part D Low-Income Subsidy program would interface with either the Medicare Savings Programs or the existing State Pharmaceutical Assistance Programs in place in all five grantee states.

### *Reconciling Eligibility Requirements and Expanding Access*

Before Medicare Part D became law, *State Solutions* program staff had been working with grantees to help them make the case in their states for disregarding all or some assets in determining eligibility for Medicare Savings Programs. Some states had already liberalized their eligibility criteria in order to break down enrollment barriers.

The Social Security Administration, however, was pushing for uniformity across all states in determining eligibility for the Part D Low-Income Subsidy program. That meant that states hoping to determine eligibility for both MSPs and the Part D subsidy at the same time might have to tighten up their MSP eligibility criteria again.

The *State Solutions* national program office, in partnership with the five grantees and others, worked to bring attention to this and other issues that might affect the goal of increasing enrollment in MSPs. Staff also provided consultant services, developed written documents and disseminated information about the interaction between MSPs and the Part D Low-Income Subsidy.

In its final Part D rules, the Centers for Medicare & Medicaid Services decided to deem Medicare Savings Programs' enrollees eligible for the Low-Income Subsidy automatically (even if they would not have otherwise been eligible for the subsidy under

federal criteria). Under the new federal rules, MSP participants would be automatically enrolled in a Part D plan if they did not choose one voluntarily. Each state continued to determine its own eligibility for MSPs, provided it met the minimum requirements set by the federal government.

*State Solutions* staff and others were instrumental in promoting these approaches, which gave states an incentive to expand enrollment in MSPs. States especially had reason to target beneficiaries of State Pharmaceutical Assistance Programs because they would automatically become eligible for the more generous pharmaceutical benefits available under the Part D subsidy.

### *Unmet Needs*

State and federal policy-makers did not address other issues raised by *State Solutions* staff, including:

- Increasing awareness of MSPs as part of the outreach and education efforts associated with the Part D Low-Income Subsidy program.
- Improving the leads data states receive from the Social Security Administration so that they include verified income and asset data, which would reduce the work required to determine eligibility for MSPs.
- Moving toward a uniform application for MSPs and the Low-Income Subsidy program to reduce the burden of filling out two applications.
- Continuing efforts to expand MSP eligibility by encouraging states to increase income limits or eliminate asset tests.

The national program office continued to work with state and federal policy-makers on these issues, hosting a national summit in March 2007 to raise their visibility. See Annual Meetings and Summits and Key Recommendations for details.

### *Diminishing Federal Interest in Improving the MSP/Low-Income Subsidy Connection*

CMS representatives who attended a 2006 *State Solutions* summit expressed interest in ideas to improve the connection between MSPs and the Part D Low-Income Subsidy program. But by the following year, interest at the federal level seemed to be waning, according to program staff.

As a result, *State Solutions* had to adapt both its agenda for a 2007 summit and its plan to pilot a uniform application for both programs. Instead, the summit focused on state-level changes and the opportunity to engage private sector partners (i.e., health plans that offer Part D drug plans).

Program staff also began developing products and issue briefs to inform other partners about relevant issues and focused more energy on involving congressional staff in the summit to represent the federal legislative perspective.

## The Implementation Phase: National Program Office Activities

Staff at the national program office provided technical assistance to the grantees and convened meetings and summits to promote exchanges among grantees and other stakeholders. Staff also produced an array of publications exploring issues related to enrollment in Medicare Savings Programs (see the Bibliography).

Toward the end of the program period, *State Solutions* also provided technical assistance to CMS, a member of Congress and state officials working to improve MSP enrollment.

### *Technical Assistance to Grantees*

The national program office provided assistance to grantees through monthly conference calls, site visits and electronic and written communications and used paid consultants to work individually with the sites.

- **Conference calls.** Each month, grantees exchanged ideas and experiences via conference calls that also included selected consultants.
- **Site visits.** National program office staff visited all the sites in the second year of the project. The visits focused on grantees' goals, accomplishments, challenges, budget issues, enrollment numbers, sustainability plans and technical assistance needs. The national program office sent memos summarizing the site visits to the grantees and to RWJF.
- **Electronic and written communications.** The national program office posted selected publications and relevant links on its website, solicited feedback on its tools and communicated regularly with grantee organizations through phone and e-mail alerts. Grantees submitted quarterly updates about their work, which were shared across projects.
- **Consultants.** The national program office subcontracted with expert consultants to provide individual technical assistance to the state sites, as needed. For example:
  - Penny Lane, a health literacy expert, traveled to Louisiana to review the state's MSP application and renewal forms and announcements. Armed with her feedback, the state agency simplified and revised its forms.
  - Sally Patterson, a strategic communications consultant and focus group moderator, provided technical assistance to an outreach team in Louisiana that had no expertise in conducting focus groups.

— Kimberley Fox, a researcher at the Muskie School of Public Service at the University of Southern Maine, provided technical assistance to several states on various issues related to MSPs.

### Annual Meetings and Summits

*State Solutions* held three annual meetings and two invitational summits at which staff at the state grantee organizations and invited guests exchanged information about their strategies and progress in enrolling eligible recipients in Medicare Savings Programs.

- Annual meetings—held in Philadelphia in 2002, New Orleans in 2003 and Chicago in 2004—provided opportunities for networking and exploring common challenges. For example, at the Chicago meeting, grantees discussed strategies for coordinating Medicare Savings Programs with the pharmacy assistance programs that many states operate for low-income people.
- The two invitational summits in Washington were:
  - *Improving Access to Health care in a Changing Landscape: Facilitating Enrollment in Medicare Savings Programs and Medicare Part D,* held May 11–12, 2006, drew more than 65 representatives from the federal and state governments, national advocacy organizations, foundations and the private sector.
  - *Finding an Easier Way: Public/Private Solutions for Increasing Medicare Savings Programs and Part D Low-Income Subsidy Enrollment,* held March 20–22, 2007, with Medicare Part D firmly in place, drew some 70 people, including state and federal officials, consumer advocates and private sector leaders. They discussed progress in integrating MSPs and the Part D subsidy program. See Key Recommendations for the action steps developed at this meeting.

### Research and Communications

*State Solutions* staff, working with the grantees and contracted researchers from universities and advocacy groups, produced an array of reports, issue briefs, articles and presentations related to enrollment in Medicare Savings Programs. See Appendix 2 and the Bibliography for more details.

A number of organizations have drawn on information from *State Solutions* about expanding enrollment, including the National Council for the Aging, the National Academy for Social Insurance, the Medicare Rights Center and the Center for Medicare Advocacy, among others.

### Technical Assistance to the Public Sector

After the 2007 summit, *State Solutions* staff and contractors engaged in an array of activities to promote policy changes related to Medicare Savings Programs and the Medicare Part D subsidies at the state and federal levels. These included:

- Providing information and technical assistance to U.S. Representative Pete Stark's office to inform deliberations on proposed federal legislation to modify rules for the Medicare Savings Programs and the Low-Income Subsidy.
- Assisting Ruth Kennedy, the Medicaid deputy director in Louisiana, in writing her May 3, 2007, testimony to the Subcommittee on Health of the U.S. House Committee on Ways and Means about her state's efforts to increase enrollment in Medicare Savings Programs.
- Sponsoring a conference call to discuss the State Pharmaceutical Assistance Programs in Maine and Vermont. Representatives from 20 states participated in the call. Contracted researcher Kim Fox facilitated the question-and-answer session following the presentations.
- Providing technical assistance to Connecticut, Indiana, New Jersey, New York, North Carolina and Pennsylvania, which were considering whether to eliminate the MSP asset test or to expand MSP income eligibility.
- Providing technical assistance to CMS on expanding or improving its outreach messages about the Medicare Savings Programs and the Part D subsidy.

### Challenges

To measure the impact of the grants, *State Solutions* sought to establish baseline enrollment data in Medicare Savings Programs that would be consistent across states. However, staff found considerable discrepancies between state and federal MSP enrollment data for reasons that varied from state to state. Rather than expend program resources to reconcile these differences, national program staff decided to track the state and federal enrollment numbers separately.

## OVERALL PROGRAM RESULTS

The national program office reported these results to RWJF:

- **In the five grantee states, enrollment in two of the Medicare Savings Programs—the Qualified Medicare Beneficiary program and the Specified Low-Income Medicare Beneficiary program—increased from approximately 447,000 in August 2002 to 646,000 in November 2005.** By contrast, there was a 22 percent enrollment increase in these programs nationwide. Broken down by state during that same time period:
  - New York increased enrollment from 176,032 to 328,543 (46 percent).
  - Pennsylvania increased enrollment from 163,392 to 168,103 (3 percent).
  - Louisiana increased enrollment from 125,151 to 163,392 (23 percent).
  - Minnesota increased enrollment from 16,586 to 19,842 (16 percent).

— New Hampshire increased enrollment from 6,144 to 9,252 (34 percent).

These data, from CMS Third Party Billing Files, correspond approximately to the three-year period during which the states were receiving grants. They do not include enrollment figures from the Qualified Individual program and other smaller Medicare Savings Programs, and many of the grantees believe they underestimate actual enrollment, according to the project director.

- **The program informed state and federal policy initiatives designed to maximize enrollment in MSPs.** For example:

  — **The Centers for Medicare & Medicaid Services sought guidance from *State Solutions* as to which messages work best to get people to apply for MSPs.** CMS also drew on some of the lessons from States Solutions in designing outreach to Medicare beneficiaries eligible for the Part D Low-Income Subsidy program.

  — ***State Solutions* arranged a conference call in which Maine and Vermont explained their strategies for expanding MSP eligibility to representatives of some 20 other states.** Subsequently, state officials from Connecticut, Indiana, New Jersey, New York, North Carolina and Pennsylvania contacted the *State Solutions* national program office for further information. The chief strategies under discussion were eliminating the MSP asset test and targeting people enrolled in State Pharmaceutical Assistance Programs.

  — **The Medicare Payment Advisory Commission, an independent congressional agency that advises the U.S. Congress on Medicare, drew on findings from *State Solutions* grantees to support recommendations it made to Congress in March 2008.** Commission staff invited *State Solutions* staff to review and comment on its final report, which urged Congress to:

    - Expand the State Health Insurance Assistance Program to fund MSP-specific outreach. The State Health Insurance Assistance Program, offered by Medicare, has counselors in every state available to provide free one-on-one help with Medicare questions.
    - Bring federal minimum eligibility criteria for Medicare Savings Programs into conformity with Medicare Part D Low-Income Subsidy criteria.
    - Require the Social Security Administration to screen and enroll beneficiaries for MSPs.

## Key Site Activities and Results

### *Grantees:*

- **Modified eligibility criteria by altering asset or income requirements and easing documentation mandates.** For example:

- In Louisiana, the state agency:
  - Disregarded life insurance policies with a face value of $10,000 or less and increased the burial fund exclusion to $10,000.
  - Dropped the requirement to verify resources when processing applications, unless the situation is questionable.
  - Disregarded in-kind support and maintenance, such as publicly provided food, clothing and shelter, as income in determining eligibility for Medicare Savings Programs.
- The New Hampshire Medicare Savings Coalition, led by the Community Services Council:
  - Persuaded the state Department of Health and Human Services to eliminate the requirement to recover costs from the estates of MSP beneficiaries after their deaths.
  - Persuaded the state to loosen the requirement that applicants provide an original birth certificate when they submit their MSP application.
  - Collaborated with the state Social Security Administration to expedite proof of citizenship for non-U.S. born applicants.
- **Expanded outreach to new communities by developing media campaigns; distributing information in community settings; and producing newsletters, brochures and other educational resources, among other strategies.** For example:
  - New Hampshire launched a media campaign that included mass mailings, public service announcements, media interviews, print ads, radio ads and several innovative advertising campaigns (including ads on a race car). The effort reached more than 1 million people across the state. The campaign distributed approximately 50,000 incentive gifts advertising MSPs along with an additional 24,000 informational brochures.
  - In Minnesota, the grantee:
    - Used CMS leads data to conduct targeted mailings around the state.
    - Expanded outreach in minority communities, including Spanish-speaking, African-American and Native American communities.
    - Provided outreach materials to community groups working with people with disabilities around the state to increase awareness, especially in rural Minnesota.

- New York developed training materials and educational resources for consumers and community advocates and regularly conducted presentations for Medicare beneficiaries and health and social services providers.
- The Louisiana Medicaid agency and its partners conducted more than 28,000 hours of outreach (see Site Profile). The agency revised its outreach strategies considerably after Hurricane Katrina forced many state Medicaid offices to close and disrupted its extensive network of partnerships.

  Supplemental RWJF grants supported that effort. A grant to the state Medicaid agency in Shreveport, La., of $147,000 (ID# 056271) allowed workers to be paid overtime for conducting outreach outside normal working hours, among other activities. A second grant (ID# 056280), for $98,100, allowed the Rutgers Center for State Health Policy to contract with Diane Allen & Associates, a Louisiana-based advertising and marketing agency, to develop a promotional campaign.

  Overall MSP enrollment increased after Katrina, even though thousands of previously enrolled individuals could not be located and had their cases closed.

— **Forged partnerships and strengthened existing coalitions.** For example:

- **The state Medicaid agency in Louisiana recruited nearly 1,400 additional partner organizations.** This effort raised the statewide total to more than 3,000 partners. Partners included other public agencies, health care and social service providers, faith-based organizations and businesses. The extent of their involvement varied considerably—some agencies displayed MSP applications prominently and made referrals, and others helped clients complete applications or created events at which they could learn more about the program.
- **In New Hampshire, several groups with similar missions began exchanging information.** At the start of the grant period, several different task forces, coalitions and working groups were focused on Medicare issues in New Hampshire. Their representatives, as well as representatives of the Centers for Medicare & Medicaid Services, began to meet monthly to talk about common concerns.
- **In New York, the Medicare Rights Center increased its coalition to 140 members.** Private, governmental and community-based groups that did not ordinarily work together collaborated to solve issues related to Medicare Savings Programs. The partnership was strengthened because each coalition member felt valued, according to the project director.
- **The Pennsylvania Campaign for Affordable Health Care added nearly 25 new groups to its coalition.** Participants included representatives of agencies

working in minority health and mental health, nurse-managed health centers and religious groups.

— **Simplified the application and renewal process for enrolling in MSPs and for maintaining benefits ("redetermination").** For example:

- The grantee organizations in Louisiana and Minnesota conducted focus groups to uncover barriers to enrollment and altered their application forms in response.
- The Minnesota grantee developed a Web-based health care application available in 11 languages and accessible from anywhere, including homes, libraries, local advocacy agencies and other states.
- New Hampshire revised its short-form MSP application, making it easier for beneficiaries to understand and use.

— **Trained staff and volunteers to conduct enrollment activities.** For example:

- In New Hampshire, the grantee recruited, trained and certified 160 new volunteers through 12 volunteer trainings. The training, offered within its Health Insurance Counseling Education & Assistance Services program, prepared volunteers to educate and advocate for beneficiaries, including visiting homebound applicants. Staff and certified volunteers participated in 392 events, involving 6,380 potential beneficiaries, at which the opportunity to enroll in MSP was offered.
- In New York, the grantee developed and revised an intensive professional training program for the New York City Deputization Project, which authorized community-based organizations and other interested parties to conduct the face-to-face interview portion of the MSP application process. Deputies helped some 1,200 New York City residents apply for the MSPs.

— **Expanded enrollment opportunities by collaborating with partners likely to have contact with MSP-eligible persons.** For example:

- The Minnesota grantee worked directly with staff of the Minnesota Food Support Program (which administers food stamp benefits) to combine outreach messages, as many potential beneficiaries are eligible for both food support and Medicare Savings Programs.
- Minnesota also engaged private health insurance plans that cover Medicare beneficiaries to promote MSP aggressively to their members and to offer them a tailored program of benefits.
- New Hampshire developed and maintained 40 new enrollment sites across the state to augment the 12 district offices of its Department of Health and Human Services.

- In New York, the grantee persuaded health maintenance organizations to offer facilitated enrollment in Medicare Savings Programs.
- In Pennsylvania, the grantee worked with partner agencies to launch several enrollment pilot projects, including:
  - Initiatives in low-income housing sites where staff made on-site presentations and offered enrollment assistance to residents, trained service coordinators and worked with property management companies to pilot test a strategy for screening residents for MSP eligibility at annual rent redetermination meetings.
  - A coordinated effort with Meals On Wheels, implemented in eight counties. This was later replicated by a coalition in Maryland.
  - An effort in four counties to screen applicants for the state's pharmaceutical assistance program to see if they also were eligible for MSPs.

— **Strengthened systems of data collection.** For example, the Louisiana Department of Health and Hospitals made computer system changes to establish an accurate baseline of the number of individuals eligible for more than one publicly subsidized health care program.

— **Engaged state legislators and government agency staff to explore barriers in the application and approval processes.** For example, the New Hampshire grantee used mailings and face-to-face meetings to educate state legislators about barriers to MSP enrollment and opportunities to streamline application and approval processes. Staff also presented data showing New Hampshire's low enrollment figures, compared with the number of people who are eligible.

## Key Recommendations

The 2007 invitational summit produced a number of recommendations and proposed action steps to increase Medicare Savings Program enrollment:

- **Simplify the administration of Medicare Savings Programs and the Part D Low-Income Subsidy program:**
  - Create uniform eligibility criteria and eliminate asset tests.
  - Make the Qualified Individual program, one of the MSPs, permanent, rather than reauthorizing it annually.
  - Update estimates of those who are eligible for MSPs but not enrolled, in order to target outreach more effectively.
  - Identify new ways to increase outreach, such as including applications in state tax forms.

- Federalize the funding and administration of MSPs, but leave states the option of maintaining administrative authority.
- Require the federal Social Security Administration to screen and enroll individuals eligible for Part D subsidies into MSPs.

- **Improve data sharing to ensure that beneficiaries are enrolled in the programs for which they are eligible:**
  - Maintain a single set of data in each state that matches federal data.
  - Reconcile data within the Centers for Medicare & Medicaid Services and between that agency and the federal Social Security Administration.
  - Allow states and Part D plans direct access to the Medicare beneficiary database.
  - Provide states access to Social Security Administration leads data that has detailed information on verified income and assets.
  - Provide access to real-time data.
  - Use residential, in-state addresses to assign MSP beneficiaries automatically to Part D plans (rather than Social Security Administration addresses, which may not reflect the beneficiaries' actual place of residence).
  - Reimburse states fully for any temporary coverage they provide when data-related problems surface.
- **Engage the private sector more fully in efforts to enroll more beneficiaries in Medicare Savings Programs and the Part D subsidy.**
  - Reassess marketing restrictions to ensure that health plans are not barred from marketing MSP and Part D subsidy programs.
  - Fund community-based organizations to provide education, outreach and application assistance to low-income populations.
  - Increase education to health plans about the function of state health insurance programs and the aging network to promote stronger partnerships.
  - Increase collaboration between the states and health plans to reduce the costs and inefficiencies of outreach done by different entities.
  - Continue and increase the contracts between health plans and brokers who can work one-on-one with qualified applicants to help them complete necessary forms.

### Key Conclusions

The *State Solutions* national program office staff reported these key conclusions from the experiences of its grantees:

- Outreach efforts were most successful when they were targeted to individuals who met the program eligibility criteria and when they included specific information about how and where to get help.
- Efforts to understand the application process from the beneficiaries' perspective helped grantees develop strategies to improve program operations.
- Policy changes that resulted in simpler application and renewal processes helped boost enrollment.
- The need persists to reach and enroll more low-income Medicare beneficiaries in the Medicare Savings Programs, as well as in the Medicare Part D Low-Income Subsidy program.

## LESSONS LEARNED

### From the National Program Office

1. **Providing resources to states to raise awareness of Medicare Savings Programs is critical to maintaining attention and concerted efforts to enroll this population.** Without dedicated funding for outreach or enrollment targets set by the federal government, states have little incentive to publicize or seek to maximize enrollment in the programs. (Summative Report to RWJF)
2. **Collaboration is the key to successful implementation of strategies for increasing MSP enrollments and to sustaining them over time.** The states that developed and nurtured strong coalitions or partnerships had the strongest programs and were able to continue their work after RWJF's grant funding ended. (Summative Report to RWJF; New York Final Report)
3. **To have national impact, the lessons learned from the experiences of individual states should be synthesized and broadly disseminated.** Attracting and maintaining the interest of federal policy-makers and decision-makers require repeated efforts. Hosting national meetings and providing information and research are useful strategies to inform policy-making. (Summative Report to RWJF)
4. **Data on MSP eligibility and enrollment are limited, and significant discrepancies exist across state and federal sources.** This makes it difficult to determine who is potentially eligible but not enrolled or to measure the impact of different interventions on overall state enrollment. For example, Minnesota's efforts to conduct targeted marketing to subpopulations were thwarted because the necessary information about

these groups was not available. (Summative Report to RWJF; Minnesota Final Report)

5. **Keep the focus of a national program on the people it is designed to serve.** "Don't think in programmatic terms-in this case, the Medicare and Medicaid programs," said Program Officer David Colby. "Think about the population you want to serve. If you think that way, you are better able to learn and adapt." (Program Officer/Colby)

### From the State Projects

6. **Community agencies are in the best position to conduct outreach and educate the population that is potentially eligible for Medicare Savings Programs.** In Minnesota, staff members at these organizations had a strong network of local community contacts and were able to "hit the ground running" to conduct focus groups, set up presentations and talk to individuals. (Minnesota Final Report)

7. **With an aging population, do not rely on electronic forms of communication.** The Minnesota grantee found that many within their target group were not computer savvy, so they relied on direct mailings and word of mouth from trusted sources, such as caregivers, to reach potential MSP enrollees. (Minnesota Final Report)

8. **Television and radio talk shows may help get the word out in some states.** Louisiana's statewide radio public service announcements yielded little response, but local radio talk shows hosted by someone who was recognized and trusted in a community did much better. (Louisiana Final Report)

9. **Coordinating and combining the outreach efforts of more than one program directed at the same population are efficient means of reaching the target group.** Minnesota intertwined its MSP initiatives with other outreach efforts to older adults, such as a food support program, which gave individuals an extra incentive to apply for MSP. (Minnesota Final Report)

10. **Programs must pursue institutional changes that can withstand turnover.** The New Hampshire coalition won early backing from the commissioner of the Department of Health and Human Services on important changes in MSP enrollment and eligibility rules, but it did not continue to push for other changes. When that commissioner left the job, coalition leaders had to start again to educate the new government official. (New Hampshire Final Report)

11. **Partnering with grassroots community groups is an effective way to conduct outreach. In Louisiana, partnerships with community organizations, providers and local agencies proved to be an excellent tool for disseminating MSP information to potential enrollees—especially people who are homebound and those who live in rural areas. The local organizations have day-to-day contact with these people and have credibility and the trust of their communities.** (Louisiana Final Report)

12. **Accurate data are essential to measuring progress.** In Louisiana, coalition workers found that the state was not accurately tracking deaths or renewals among MSP enrollees, which skewed overall enrollment numbers. This made it difficult to track their progress in increasing MSP enrollment. (Louisiana Final Report)

13. **Even after enrollment forms and processes have been streamlined, potential enrollees need help navigating the application process.** Face-to-face or phone contact remains an important step in enrollment. (Louisiana Final Report)

14. **Distributing promotional items as part of MSP outreach efforts can draw potential beneficiaries.** The Louisiana outreach team distributed pill boxes, pens and pencils, key rings, coin purses, note pads and other items at health fairs, churches, festivals, shopping malls and other community settings in order to attract interest in MSPs. Groups need to make sure that they have an adequate supply of promotional items when they set up informational tables. (Louisiana Final Report)

15. **Project grantees should be encouraged to call on national program office staff for technical assistance.** The Louisiana coalition encouraged grantees of national programs to "take advantage of any technical assistance made available during the project. Identify additional technical assistance that would be helpful in completing project activities and make a request to the national program office." (Louisiana Final Report)

## AFTERWARD

Many of the organizations and consultants involved in *State Solutions* continued work on issues related to Medicare Savings Programs. For example:

- The Rutgers Center for State Health Policy, which served as the national program office, continued to provide technical assistance and information to state and federal policy-makers involved with Medicare Savings Programs.
- The national program office built strong relationships with national organizations that continued to work for improvements in MSP outreach, education and administration, such as the National Council on Aging, the Medicare Rights Center and the Center for Medicare Advocacy.
- *State Solutions* consultant and researcher Kimberley Fox continued to advise states interested in expanding MSP eligibility. For example, she helped inform legislation in Connecticut that expanded MSP income eligibility to levels set by the state's pharmaceutical assistance program.

All of the grantees continued to provide some level of MSP outreach work, with many continuing the kinds of activities launched under *State Solutions* . For example:

- In New Hampshire, the Community Services Council maintained a part-time position within its Health Insurance Counseling Education & Assistance Services program,

which gave a single individual primary responsibility for coordinating Medicare Services Program activities.

- In New York, the Medicare Rights Center has absorbed many of the activities of the Medicare Savings Programs Coalition. The center designed a screening tool so that everyone who calls its hotline is screened to determine his or her eligibility for MSPs and the Part D subsidy. The center is exploring a possible collaboration with the New York City Housing Authority.

**Prepared by: Kelsey Menehan**
Reviewed by: Karyn Feiden and Marian Bass
Program officers: David Colby and Stuart Schear

## APPENDIX 1

### National Advisory Committee

*(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)*

**Susan O. Raetzman, Chair**
Associate Director, Public Policy Institute
AARP
Office of Policy and Strategy
Washington, D.C.

**RoAnne Chaney**
Senior Program Officer
Center for Health Care Strategies
Michigan Disability Rights Coalition
East Lansing, Mich.

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## APPENDIX 2

### Researchers Under Contract With *State Solutions*

*(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)*

**Kimberley Fox,** a researcher at the Muskie School of Public Service at the University of Southern Maine, helped *State Solutions* prepare for its 2007 invitational summit by:

- Collecting survey data from 20 state pharmaceutical assistance programs on their planning around eliminating asset eligibility requirements in the MSPs as a result of Medicare Part D.
- Tracking news/literature about Part D Low-Income Subsidy experience and relevance for MSP.
- Performing research on "Clawback" payment state requirements for Medicare Part D and implications for asset test elimination in QMB Plus states. Clawback is a monthly payment made by each state to the federal government to help fund the Medicare Part D benefit.

- Assisting with the planning and implementation for an Low-Income Subsidy session at a State Pharmaceutical Assistance Program meeting in Washington sponsored by the National Governors' Association to include a discussion of MSP asset test elimination as one strategy for State Pharmaceutical Assistance Programs to increase Low-Income Subsidy enrollment.
- Analyzing MSP data across states to identify trends in MSP enrollment and states that appeared to have higher rates of enrollment increases to invite as potential speakers for the meeting.
- Conducting a literature review for an issue brief on Vermont, Maine and District of Columbia case studies and developing interview protocol questions for case study states.
- Participating in internal CMS conference calls on Third Party Billing data to clarify inconsistencies in data and the relationship with other CMS data sources, for example, Medicare Modernization Act file data to assess validity of data for tracking MSP trends by program and state. Identified limitations in data (e.g., only reliable data are total Part B buy-in, not program-specific enrollment).
- Reviewing and revisiting cost/benefit analysis of MSP eligibility expansions in New Jersey.

**Laura Summer,** a researcher at Georgetown University Health Policy Institute in Washington, wrote four papers describing:

- Accomplishments and lessons learned from *State Solutions* .
- Administrative costs associated with enrollment and renewal for MSPs.

**Shoshanna Sofaer,** a researcher in the School of Public Affairs at Baruch College in New York, wrote two papers:

- Assessing the *State Solutions* project.
- Assessing the Louisiana *State Solutions* project.

**Randall Blume,** a consultant with Blume Associates, wrote three papers about grantees' efforts to expand MSP enrollment through:

- Linking state prescription programs with MSPs.
- Outreach to public housing settings.

See the Bibliography for details.

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## Sponsored Conferences

"Finding an Easier Way: Public/Private Solutions for Increasing Medicare Savings Programs and Part D Low-Income Subsidy Enrollment," Invitational Summit, March 20–22, 2007, Washington.

## Presentations and Testimony

Kimberley Fox, "Maximizing Enrollment in Transitional Assistance: Lessons from Medicare Discount Cards and Other Low-Income Enrollment Initiatives," presented on a Web conference call, jointly sponsored by the National Governor's Association Center for Best Practices and the Centers for Medicare & Medicaid Services, December 16, 2004.

Kimberley Fox, "Opportunities for Expanding Medicare Savings Program Enrollment Under Medicare Part D," at the *State Solutions* summit Improving Access to Health Care in a Changing Landscape: Facilitating Enrollment in Medicare Savings Programs and Medicare Part D, May 11, 2005, Washington.

S. Patterson, "Conducting Focus Groups for Individuals with Disabilities," Radiant Communications, April 14, 2004, New Orleans. Documents resulting from this workshop include:

- Caregiver's Questionnaire
- Checklist for Focus Group Interviews
- Focus Group Worksheet
- Moderators and Moderating
- Moderator's Guide
- MSPs Application Focus Group
- Sample Agenda
- Tips on Interacting with People with Disabilities

## World Wide Websites

*www.statesolutions.rutgers.edu* (no longer available). The website for *State Solutions* included links to many of the publications and presentations produced during the program.

## PROFILE LIST

### Louisiana

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## SIDEBAR LIST

- Intensive Outreach Spurs Increase in MSP Enrollment in Louisiana

## PROJECT LIST

### *Louisiana*

**State of Louisiana Department of Health and Hospitals** (Baton Rouge, La.)

Amount: $ 419,017

Dates: June 2002 to June 2005

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**State of Louisiana Department of Health and Hospitals** (Shreveport, La.)

Amount: $ 147,000

Dates: January 2006 to February 2007

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### *Minnesota*

**State of Minnesota Department of Human Services** (St. Paul, Minn.)

Amount: $ 120,000

Dates: July 2002 to September 2005

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### *New Hampshire*

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Amount: $ 420,000

Dates: July 2002 to September 2005

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