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MEDICAID PROGRAMS TO ASSIST LOW-INCOME MEDICARE BENEFICIARIES: MEDICARE SAVINGS PROGRAMS CASE STUDY FINDINGS

Prepared by
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The National Senior Citizens Law Center
Washington, DC
for
The Kaiser Commission on
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December 2002

* Kim Glaun is currently the Washington, DC Counsel for the Medicare Rights Center

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of The Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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The report is dedicated in memory of Burton D. Fretz, the National Senior Citizens Law Center's former Executive Director, who dedicated his career to promoting the rights and well-being of older adults and the underserved.

Executive Summary

Background

Though Medicare assistance is vital to the 40 million elderly persons and individuals with disabilities enrolled in the program, the requirement that beneficiaries contribute to the cost of their care through premiums and coinsurance can impose a significant burden on low-income individuals. The poorest Medicare beneficiaries are eligible for protection from these medical expenses through the Medicaid program, but many persons living just below or above the poverty level are not eligible for full Medicaid assistance and cannot afford private supplemental insurance to help cover these costs. The Medicare Savings Programs are designed to assist these low-income Medicare beneficiaries with the cost of Medicare premiums and coinsurance by paying all or some of these costs.

Despite their promise, the Medicare Savings Programs have historically failed to reach many persons eligible for assistance. Policymakers and the federal Centers for Medicare and Medicaid Services have encouraged states to address barriers to enrollment by easing financial eligibility rules and enhancing the benefit package, streamlining application forms and enrollment procedures, and enhancing outreach efforts. This report summarizes findings from case studies of five states that are implementing many of these practices. (See Table A for state-by-state information.)

Principal Findings

Easing Financial Eligibility Rules and Enhancing the Benefit Package

- *The Medicare Savings Programs asset limits are a major barrier to enrollment.* Both state officials and other stakeholders in the case study states reported that the asset limits, which have not been changed since 1989, do not reflect the financial status of most low-income beneficiaries that the programs aim to assist. In addition, they said that the onerous task of verifying the worth of various assets deters or prevents many eligible individuals from completing applications and causes additional paperwork for state agencies.

- *Eliminating the asset test for the Medicare Savings Programs can enable more individuals to qualify for benefits, simplify enrollment for both beneficiaries and state agencies, and be cost-neutral for states*. State officials in the case study states that eliminated or increased asset limits (AZ, CT, and MN) believed this action helped the programs reach more low-income beneficiaries who needed assistance. In the states that dropped the asset test altogether (Arizona for all Medicare Savings Programs and Connecticut for the QI program), state officials reported that the change alleviated staff workloads, make the application process easier for beneficiaries, and promoted community-based application assistance. Importantly, state officials also reported that the action was cost-neutral for states, noting that in some cases the benefit is fully funded by the federal government and that the administrative costs saved approximated the cost of additional enrollment.

- *Individuals' fear of Medicaid estate recovery—even in states that do not recover funds from the estates of beneficiaries whose assistance from Medicaid was limited to payment of Medicare premiums and cost sharing—often deters enrollment and undermines state efforts to promote participation*. The case studies revealed widespread misunderstanding of estate recovery rules and fear among potential enrollees that receipt of benefits would allow states to immediately seize their homes. Even those who understand estate recovery rules may resist enrolling in order to preserve a small inheritance for their families.

- *Enhancing the benefit available to Medicare Savings Program enrollees—for example, by offering the full range of Medicaid benefits or linking eligibility to a state-operated pharmacy assistance program—can persuade eligible individuals to apply for benefits.* Policy makers have speculated that the limited nature of the Medicare Savings Program benefit leads some eligible individuals to perceive that the value of the program does not warrant the effort of applying. As such, some states have expanded the benefit available and attracted more people to the program.

Streamlining and Facilitating Application, Enrollment, and Renewal

- *States can simplify application forms without undermining program integrity.* All of the case study states had adopted simplified Medicare Savings Programs application forms, which were uniformly lauded as an improvement over the traditional application materials. Most states eventually waived documentation requirements, relying on automated collateral verification systems to detect inaccuracies. States that had done so did not report an increase in errors in fraud.

- *Relying on community-based organizations to help applicants enroll in the Medicare Savings Programs is a promising approach to providing the personalized help that many older people require when applying for benefits. However, lack of funding and intricate enrollment processes can stymie these efforts.* Even after states simplified their application forms, many applicants required assistance with the enrollment process. In all study states, State Health Insurance Assistance Programs (SHIPs) provided counseling and application assistance. Two states (AZ and WA) also had success in providing seed money and training to community-based organizations to establish additional application assistance in underserved communities. However, Indiana's experience with alternate application sites—in which the state did not provide money and training—showed that without support, community-based organizations are unlikely to generate many applications.

- *Eligibility renewal remains a challenge in maintaining participation in the Medicare Savings Programs.* The study states had generally focused their Medicare Savings Program promotion efforts on simplifying the application and enrollment processes and have paid less attention to streamlining the renewal process. State officials confirmed that renewal challenged continuity of coverage, as some seniors did not complete the process due to cognitive or physical impairments, change of address, or hospitalization.

Enhancing Outreach Efforts

- *By targeting mailings to potentially eligible individuals—such as those enrolled in a state pharmacy assistance program or newly-eligible Medicare beneficiaries with Social Security incomes near the poverty level—state outreach activities can generate a number of applications.* States that used these approaches to mailing outreach materials (CT and IN) experienced response rates between 11 and 16 percent. In contrast, commercial mailing lists yielded a much lower response (about one percent).

- *Collaborations between the Medicaid agency, the Social Security office, and the State Health Insurance Counseling Program may generate better results than those with the Medicaid agency alone*. Because the Social Security Administration is highly trusted among older persons, officials in the case study states thought the agency's involvement engendered positive response to outreach efforts. Furthermore, officials in the majority of the study states believed that partnerships with SHIPs, which are well-attuned to the needs of older persons, provided key counseling and application assistance.

- *Federal support of state outreach activities through technical support and grant funds enables states to foster collaborative partnerships and to develop innovative outreach approaches specially targeted to under-served populations.* All of the study states used federal grant funding to test innovative outreach practices, in particular those that involved building relationships with local groups to enroll "hard-to-reach" populations.

Table A: Summary of Medicare Savings Programs Activities in Case Study States

Arizona	Connecticut	Indiana	Minnesota	Washington
Easing Financial Eligibility				
· No asset test for Medicare Savings Programs and Medicaid · Full Medicaid benefits for individuals up to 100% FPL · No estate recovery for Medicare Savings Programs benefits	· Income disregards of $183 (single) and $336 (couple) · No asset test for QI	(None)	· State pharmacy assistance program eligibility premised on QMB/SLMB enrollment · Medicare Savings Programs asset levels increased to $10,000 for a single person and $18,000 for a couple · Income eligibility level for full Medicaid increased to 100 % FPL	· No estate recovery for Medicare Savings Programs benefits
Streamlining and Facilitating Enrollment				
· Mail-in simplified application available on Medicaid website (in English and Spanish) · Universal Medicaid application · No in-person interview	· Mail-in, simplified application available on CT Legal Services website (in English and Spanish) · Self-certification of income & assets	· Mail-in simplified application available on Medicaid website (in English and Spanish) · No in-person interview required · Community enrollment sites used	· Mail-in simplified application form available on Medicaid website in 10 languages · Pilot "seniors-only" form · Allow self-certification of assets · No in-person interview required	· Mail-in simplified application form · No in-person interview required · Self certification of assets and income (implemented in 2002)
Streamlining and Facilitating Renewal				
· No in-person interview or asset documentation at yearly renewal	· No in-person interview or documentation at yearly renewal	(None)	· No in-person interview or documentation of assets required at yearly renewal	· No in-person interview required at yearly renewal

Arizona	Connecticut	Indiana	Minnesota	Washington
Enhancing Outreach and Partnerships				
· CMS grant to SHIP to collaborate with SSA (Jan.–Dec 2001) · Extensive SHIP outreach & application assistance · Strengthened Medicaid & SHIP partnership · $1 million Medicaid outreach grant to community groups & providers · Outreach on Tribal lands	· Use of CMS leads data for targeted mailings · CMS partnership outreach grant (October 2000–December 2001) · Targeted mailings w/AARP to state pharmacy assistance program recipients and low-income households · Medicaid partnership with SHIP & community providers · Tracking of outreach methods	· SSA Buy-in Demonstration: Application model site (Evansville, 1999) · Use of leads data for targeted mailings · CMS SHIP grant for radio PSAs targeted to rural and Hispanic populations (Jan–Dec. 2001) · Inter-agency partnership (1999)	· CMS partnership grant (October 2000–December 2001) for outreach/media campaign in rural under-served areas · Use leads data for targeted mailings · Partnership between state Medicaid agency and State Unit on Aging/SHIPs Senior LinkAge® Line · Track outreach methods	· CMS partnership grant (Oct. 2000–Dec. 2001) to Medicaid agency and the Medicare Savings Coalition to develop culturally appropriate outreach to underserved populations · CMS Medicare Ombudsman grant (October 1999–October 2000) · SSA demonstration mailing in Western zip codes (November 2000–February 2001) · Targeted mailings with AARP
Obstacles Identified				
· Misapprehen-sions about estate recovery · Renewal process	· Asset test for QMB & SLMB · Fear of estate recovery · Welfare stigma · Potential for reduced access to providers for QMBs · Renewal process	· Need for personal interview, multiple verifications to apply · Fear of estate recovery · Asset test · Welfare stigma · Lack of tracking for outreach · Renewal process	· Estate recovery · Welfare stigma · Reaching rural, underserved populations · Renewal process	· Asset test · Welfare stigma · Misapprehen-sions about estate recovery · Computer problems · Renewal process

Introduction

The Medicare program, which covers 40 million elderly persons and individuals with disabilities, provides vital assistance with medical bills but requires enrollees to assist in paying for their health care expenses. Beneficiaries pay significant out-of-pocket amounts on Medicare premiums, deductibles, and co-insurance each year. In 2000, the average elderly Medicare beneficiary in traditional Medicare spent $1,636 on premiums and cost sharing.[1] Beneficiaries also pay for services that are not covered by Medicare, bringing the average elderly Medicare enrollee's out-of-pocket spending on health services to over $3,000 per year.[2] These costs are especially burdensome for the 15.8 million beneficiaries who are poor or low income.[3] Low-income older persons and individuals with disabilities tend to have poorer health than their wealthier counterparts and spend over a third of their annual incomes on overall medical costs, in contrast to 10 percent for higher income beneficiaries.[4]

The poorest Medicare beneficiaries are eligible for protection from medical expenses through the Medicaid program, which provides assistance with beneficiary premiums and cost sharing and also provides benefits not covered by Medicare, such as prescription drugs and extended long-term care. Yet, many persons living just below or above the poverty level do not qualify for the complete array of Medicaid coverage and cannot afford private supplemental insurance to help pay for Medicare cost-sharing or services not covered by Medicare.

In 1988, Congress enacted the Medicare Savings Programs, also known as the "Medicare/Medicaid Buy-in Programs," to provide much needed financial assistance with Medicare expenses to low-income beneficiaries. The Medicare Savings Programs pay some or all of the Medicare cost sharing and premium amounts for Medicare beneficiaries with low incomes and resources, who generally cannot qualify for full Medicaid benefits. In 2002, the Medicare Savings Programs were available for persons with incomes up to 175 percent of the Federal Poverty Level (FPL) and limited assets; in 2003, they will be available for individuals with incomes up to 135 percent FPL.

Despite their promise, the Medicare Savings Programs have historically failed to reach many persons eligible for the programs. Numerous reports during the 1990s identified reasons for the under-enrollment, including: lack of knowledge about the programs; the administrative complexity of enrolling; the perceived stigma of applying for a Medicaid program; fear and misapprehensions about estate recovery practices; and cultural and language barriers.[5] To

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[1] Maxwell, Stephanie, Marilyn Moon, and Misha Segal, *Growth in Medicare and Out-Of-Pocket Spending: Impact on Vulnerable Beneficiaries*, the Urban Institute, January 2001.
[2] Ibid.
[3] Moon, Marilyn, Robert Friedland, and Lee Shirey, *Medicare Beneficiaries and their Assets: Implications for Low-Income Programs,* Kaiser Family Foundation, June 2002 [Hereafter *Asset Implications*]
[4] *Medicaid's Role for Low-Income Beneficiaries*, the Kaiser Commission on Medicaid and the Uninsured, January 2002.
[5] *See, e.g.,* Nemore, Patricia B., *Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries: A 1999 Update*, the Henry J. Kaiser Family Foundation, December 1999[Hereafter *Variations 1999*], General Accounting Office. *Low-Income Medicare Beneficiaries: Further Outreach and Administrative*

promote greater use of the Medicare Savings Programs, policymakers and CMS have encouraged states to address these barriers and have sought to identify promising strategies to improve enrollment. These strategies entail easing financial eligibility rules and enhancing the benefit package, streamlining application forms and enrollment procedures, and enhancing outreach efforts.

In 1997 and 1999, the Henry J. Kaiser Family Foundation commissioned the National Senior Citizens Law Center to survey state Medicaid directors and advocates in the 50 states and the District of Columbia about their polices affecting Medicare Savings Programs participation. The studies found wide variations among states in their Medicaid rules and practices, as well as in the extent to which they had adopted promising techniques to promote Medicare Savings Programs enrollment.

Following up on these surveys, this report presents detailed cases studies of efforts to boost Medicare Savings Programs enrollment in five states: Arizona, Connecticut, Indiana, Minnesota, and Washington. The study states represent a range of geographic regions, sizes, and demographic distributions. Additionally, CMS monitoring efforts indicated these states had: (1) recently initiated recommended tools to promote the Medicare Savings Programs; and (2) experienced above-average gains in enrollment. The data included in this report is current as of December 2001. Table 1 compares characteristics of the study sites.

This report presents an overview of the practices available to states to promote Medicare Savings Programs enrollment and highlights lessons learned about these strategies in the study states. The five case studies, available in a separate report, include detailed descriptions about outreach and enrollment practices, the perceived impact of these efforts, challenges and barriers experienced, and lessons learned.

Simplification Could Increase Enrollment, GAO/HEHS-99-61, April 1999 [Hereafter *GAO-1999*], Margo Rosenbach & Lamphere, JoAnn, *Bridging the Gaps Between Medicare and Medicaid: The Case of QMBs and SLMBs,* AARP Public Policy Institute, January 1999 [Hereafter *AARP 1999*]; Families USA. Shortchanged: Billion Withheld from Medicare Beneficiaries, 1998 [Hereafter *Shortchanged]*.

Table 1: Characteristics of Case Study States

State (Region)	Arizona (SW)	Connecticut (NE)	Indiana (Midwest)	Minnesota (Midwest)	Washington (NW)	United States
Total Population (2000-2001)[6]	5,235,348	3,374,256	6,018,429	4,905,736	5,880,984	279,972,786
Percent of Total Population Enrolled in Medicare (2000-2001)[7]	12.6%	15.7%	14.9%	10.3%	13.2%	13.5%
Percent of Medicare Population Below Poverty Level (2000-2001)[8]	13.4%	10.3%	12.7%	12.4%	13.2%	16.5%
Aged & Disabled Medicaid Income Eligibility Level for Full Benefits (2001)[9]	100% FPL	64% FPL	74% FPL	100% FPL	78% FPL	74% FPL (federal minimum)
Number Enrolled in Medicare Part B Buy-In Programs (2001)[10]	59,000	54,000	89,000	66,000	93,000	5,517,000
Growth Rate for Enrollment in Buy-In Programs (9/98 – 9/01)[11]	29.4% (15,213)	13.9% (7,192)	19.5% (15,503)	17.1% (9,993)	18.8 % (15,456)	10.1%
Percent of Eligible Persons Enrolled in Buy-In Programs (2001)[12]	45.4%	56.5%	49.5%	45.8%	57.7%	59.5%

Background on the Medicare Savings Programs

Low-income persons who are eligible for Medicare Part A and/or B and some form of Medicaid are known as "dual eligibles." (See Appendix A for CMS List and Definition of Dual Eligibles)**.**

[6] Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2001 and 2002 Current Population Survey, 2002. Excludes institutionalized population.
[7] Ibid. Includes only non-institutionalized beneficiaries.
[8] Ibid. Includes only non-institutionalized beneficiaries.
[9] Includes maximum SSI/Social Security Benefit.
[10] Actuarial Research Corporation, *Dual Eligible Buy-In Status*, prepared for the Centers for Medicare and Medicaid Services, May 2001[Hereafter *ARC 2001*].
[11] CMS. *Three Year Dual Eligible Enrollment Growth Rate*, September 2001.
[12] *ARC 2001.*

Depending on an individual's income and assets, as well as the eligibility rules of the state in which they live, Medicaid can cover some or all of Medicare beneficiaries' out-of-pocket medical costs. If dual eligibles qualify for full Medicaid benefits, Medicaid will also fill the gaps in Medicare benefits, such as prescription drugs and long-term care.

There are various paths for Medicare beneficiaries to qualify for full Medicaid coverage (see Table 2). The most common route is by qualifying for cash assistance through Supplemental Security Income (SSI), which triggers automatic eligibility for full Medicaid benefits. The income eligibility limit for SSI is about 74 percent of the federal poverty level. In many states, an individual found eligible for SSI will be automatically enrolled in full Medicaid by the Social Security Administration and will not need to submit a separate Medicaid application. Some states require SSI applicants to apply separately for Medicaid benefits. Additionally, persons who do not qualify for SSI can still qualify for full Medicaid coverage if their state has opted to expand Medicaid eligibility to include elderly and disabled individuals with incomes at or below 100 percent FPL. Finally, Medicare beneficiaries can qualify for Medicaid after exhausting their finances to pay for medical treatment (commonly referred to as "spending-down").

First established by Congress in 1988 and then expanded throughout the 1990s, the Medicare Savings Programs were intended to extend the protections of the Medicaid program to low-income persons who may not be otherwise eligible for full Medicaid benefits. The Medicare Savings Programs are administered and operated by state Medicaid agencies, with federal oversight by the Centers for Medicare and Medicaid Services (CMS). In general, beneficiaries must apply for the benefits with their state Medicaid agency and show that their income and assets are sufficiently low to qualify. The programs are available for persons with incomes up to 175 percent of poverty (in 2003, the upper income limit will drop to 135% of poverty) and countable assets worth no more than $4,000 for a single person and $6,000 for a couple. The Medicare Savings Programs include:

- **Qualified Medicare Beneficiary (QMB) program**: Medicaid pays all Medicare cost sharing, i.e., all Part A and B premiums, deductibles, and coinsurance. The income limit for QMB is at or below the federal poverty level (FPL) — $759 a month for a single person and $1,015 for a couple in 2002.[13] Eligible persons can receive QMB without full Medicaid benefits or QMB in addition to full Medicaid benefits, depending on the state in which they live. Unlike other Medicaid benefits, which allow three months' retroactivity, the QMB benefits can only begin during the first month following the month in which eligibility has been determined.

- **Specified Low-Income Medicare Beneficiary (SLMB) program**: Medicaid pays the Part B premium ($54 a month in 2002), but no other Medicare cost sharing. The beneficiary's monthly income must be at or below 120 percent FPL ($906 and $1,214 per month for individuals and couples in 2002, respectively). Individuals can be enrolled in SLMB without full Medicaid benefits or SLMB in addition to full Medicaid benefits, depending on the state in which they live. Unlike QMBs, SLMBs are entitled to three months' retroactive coverage if they met the eligibility requirements in those months.

[13] The 2002 income limits for all of the MSP benefits include the SSI $20 monthly income disregard.

- **Qualifying Individual (QI) programs**: Medicaid pays some or all of the Part B premium for persons who are not otherwise eligible for Medicaid. Like SLMBs, QIs are entitled to three months' retroactive benefits if they were eligible during such time. Unlike QMB and SLMB, which are entitlements, the QI programs are funded by five-year federal block grants, authorized from January 1, 1998 to December 31, 2002. States must serve eligible persons on a first-come, first-served basis, up to a legislatively determined cap.
    - **QI-1:** Medicaid pays the entire Part B premium. The income eligibility limit is between 120–135 percent of FPL ($1,017 and $1,369 per month for individuals and couples, respectively, in 2002). This benefit has been temporarily extended until March 2003.
    - **QI-2:** Medicaid pays a small part of the Part B premium ($3.91 per month in 2002). The income eligibility limit is 175 percent of FPL ($1,313 and $1,762 per month for individuals and couples, respectively, in 2002).[14] This benefit will terminate as of January 1, 2003.

Table 2: Medicaid Programs to Assist Low-Income Medicare Beneficiaries

Program	Income Limits (% of Federal Poverty Level)	Resource Limits (Individual/ Couple)	Funding	Benefits
Full Medicaid	Varies by state; 74–100%*	$2,000/$3,000*	Medicaid funded entitlement	Full Medicaid benefits
QMB	Up to 100%	$4,000/$6,000	Medicaid funded entitlement	Medicare premiums, deductibles and coinsurance**
SLMB	100–120%	$4,000/$6,000	Medicaid funded entitlement	Medicare Part B premiums
QI-1	120–135%	$4,000/$6,000	Federal block grant, first-come, first-served; will expire in March 2003	Medicare Part B premiums
QI-2	135–175%	$4,000/$6,000	Federal block grant, first-come, first-served; expires 1/03	Portion of Medicare Part B premiums– $3.91/mo. in 2002

* Section 209(b) states may use more restrictive eligibility requirements for full Medicaid benefits, as long as they are no more restrictive than those in effect in the state's Medicaid plan as of 1/1/72.
** States are not required to pay for Medicare coinsurance if the Medicaid payment rates for a given service are sufficiently lower than the Medicare payment rates.

[14] The amount of the Part B premium subsidy represents the amount attributable to transferring some home health services from Part A to Part B Medicare in the Balanced Budget Act of 1997. P.L 105-33.

The Medicare Savings Programs seek to promote the financial well-being of low-income Medicare beneficiaries, and once persons are enrolled, they realize a direct financial benefit. First, the monthly Medicare Part B premium (about $650 annually) is no longer withheld from their monthly retirement or disability check because the state Medicaid program assumes payment of those premiums. Second, for people enrolled in the QMB program, the Medicare Savings Programs will also eliminate other Medicare cost-sharing throughout the month and Part A and B deductibles and co-insurance, which Medicare beneficiaries otherwise must pay.[15]

Despite their financial benefits, the Medicare Savings Programs have failed to reach many eligible beneficiaries. Numerous reports have documented the extent of this problem. Estimates of participation rates have ranged from 45 to 63 percent for the QMB and SLMB programs combined.[16] In 2001, CMS found that 40.5 percent of those eligible for those programs were unenrolled.[17]

Federal Medicare Savings Programs Initiatives

Centers for Medicare and Medicaid Services GPRA Initiative

In response to the documented under-enrollment in the Medicare Savings Programs, in July 1998, President Clinton announced a new federal initiative to improve participation in the Medicare Savings Programs. CMS was designated to carry out the initiative to begin to find and enroll more dual eligibles through a new Government Performance Results Act (GPRA) measure.[18] Under CMS' GPRA goal, the agency undertook a number of initiatives to increase enrollment of dual eligibles, including:

- Devising and measuring progress toward national and state enrollment goals for increased dual eligible enrollment;
- Requesting quarterly reports from states regarding Medicare Savings Programs outreach and administrative simplification activities;
- Developing and disseminating Medicare Savings Programs training and outreach materials for states, beneficiary groups, State Health Insurance Assistance Programs (SHIP) counselors, and other groups;
- Designing a Medicare Savings Programs model application form;
- Providing grant funds to state Medicaid agencies, SHIPs, and National Advocacy and Protection Systems to test and promote innovative Medicare Savings Programs outreach and assistance techniques;
- Holding national and regional training conferences for Medicare Savings Programs stakeholders;

[15] Persons 65 and older who lack sufficient work history to qualify for premium-free Part A may purchase it voluntarily for a premium ($319 monthly in 2002).
[16] See, e.g., Barents Group for CMS (1999), Kalpman Rupp & Sears, James, Social Security Administration, 2001.
[17] See *ARC 2001*. Social Security Administration (2001). As of September 2002, less than 96,000 of persons were enrolled in QI-1, although 515,000 were potentially eligible. Laura Summer and Friedland, Robert, The Role of the Asset Test in Targeting Benefits for Medicare Savings Programs, the Commonwealth Fund, October 2002.
[18] Sally K. Richardson, Director, Center for Medicaid and State Operations, Health Care Financing Administration, *Letter to State Medicaid Directors*, October 16, 1998.

- Encouraging states to obtain and use CMS "leads data"; and
- Maintaining a Medicare Savings Program/Dual Eligibles homepage on the CMS website.

During the course of the three-year initiative, enrollment for all dual eligibles increased 10 percent, from 5,167,000 in September 1998 to 5,688,183 in September 2001.[19] (See Appendix B for more information on CMS GPRA Activities).

Social Security Administration National Buy-In Demonstration

Based on a Congressional mandate, from March 1999 to September 2000, the Social Security Administration (SSA) conducted a demonstration program to explore the effect of using various levels of involvement by SSA field offices to increase participation in the Medicare Savings Programs. The project tested seven different models, all of which used letters mailed to potentially eligible individuals, at about 30 sites in 16 states. In the first six models, SSA invited recipients to contact a toll-free SSA number to be screened for eligibility. Five of the six models used SSA representatives to screen callers, and one relied upon AARP volunteers. If persons appeared eligible, an interview was scheduled for them at: (1) their local Medicaid office; (2) the local SSA field office (with a Medicaid eligibility worker conducting the interview); or (3) their local SSA field office (with an SSA employee conducting the interview). While one model relied on SSA workers to conduct eligibility determinations, in all other models, applications were forwarded to the local Medicaid agency for determination. In some instances, SSA developed posters, Public Service Announcements, and articles in print media to promote the project. In the seventh model, SSA mailed a letter and simplified application, with instructions for the recipient to return completed applications to their local Medicaid office.

According to an analysis by the Lewin Group, SSA's mailing produced a reply rate of about 7.5 percent and enrolled about 4 percent of persons who were sent letters. The model with the largest impact involved the use of SSA employees to conduct the initial interview, provide application assistance, and conduct eligibility determinations. The model using a mailing packet with a short form application resulted in the lowest enrollment (1.3 percent nationally). In all, the SSA Demonstration increased enrollment about 7 percent nationally.[20]

Overview of State Model Practices

The federal government and policymakers have identified promising outreach and enrollment activities for states to increase Medicare Savings Programs enrollment rates.[21] This section describes these model practices and highlights lessons learned about them based on the experiences of the five case study states.

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[19] See *The Center for Medicare and Medicaid Services Performance on the Government Performance and Results Act Measure To "Improve Access to Care for Elderly and Disabled Medicare Beneficiaries Who Do Not Have Public or Private Supplemental Coverage,"* Center for Medicaid and State Operations, Disabled and Elderly Health Program Group, the Centers for Medicare and Medicaid Services, April 15, 2002.

[20] Alecxih, Lisa, Farrell, Mary, Ankrah, Sam & Olearczyk, BrieAnee *Results from the SSA Buy-In Demonstration: Final Report,* prepared for the Social Security Administration by the Lewin Group, October 4, 2001[Hereafter *SSA Buy-in Final*].

[21] See, e.g., *Variations 1999*;*GAO-1999*; *AARP 1999*.

For purposes of this analysis, we distinguish between the outreach and enrollment practices as follows:

- **Easing Financial Eligibility Rules:** These efforts include those that aim to increase and simplify eligibility for the Medicare Savings Program, such as increasing the asset limit, eliminating the asset test altogether, and eliminating estate recovery.

- **Enhancing the Medicare Savings Program Benefit:** Strategies to enhance the benefits include providing full Medicaid benefits to persons with incomes at or below 100% FPL and linking Medicare Savings Program benefits to state prescription drug assistance programs.

- **Streamlining and facilitating application, enrollment, and renewal processes:** Such initiatives include adopting shortened application and renewals forms; eliminating requirements for verifications and in-person interviews; providing application assistance through out-stationed eligibility workers, State Health Insurance Assistance Programs (SHIPs), and community-based organizations; and addressing administrative and systems issues.

- **Enhancing outreach and developing partnerships to reach underserved populations:** Practices in this area include using data to target outreach and mailings; tracking outreach methods to evaluate their effectiveness; forging coalitions involving all Medicare Savings Programs stakeholders to develop and conduct culture- and language-appropriate outreach interventions to minority and underserved populations; and forming strong partnerships between the State Medicaid agency and SHIPs to conduct outreach.

In practice, these classifications are not mutually exclusive and often overlap. In fact, the most effective interventions by states involve a combination of these strategies.

Easing Financial Eligibility Rules

States' financial eligibility policies and program design have a significant effect on Medicare Savings Programs participation rates. States have considerable flexibility to shape their Medicaid programs and Medicare Savings Programs in ways intended to promote enrollment. These options and lessons learned about them from the case studies are discussed below. (See Table A for detail on specific states' activities in this area.)

Increasing or Eliminating Asset Limits

To qualify for the Medicare Savings Programs, applicants must meet income and asset requirements for eligibility. The Medicare Savings Programs employ SSI income eligibility guidelines in computing monthly incomes. Similarly, the Medicare Savings Programs employ the SSI methodology for counting resources, and the Medicare Savings Programs asset standard ($4,000 for individuals and $6,000 for couples) is set at twice the SSI level. Yet, federal law

affords states wide latitude to devise financial eligibility policies that are more generous that those employed by SSI.[22] For instance, states have the option to increase income disregards to extend the Medicare Savings Programs to persons with more income than would otherwise be permitted under the SSI rules. Federal law also permits states to adopt less stringent methods of counting assets for the Medicare Savings Programs. States can adopt more generous resource disregards than SSI and can eliminate consideration of assets altogether, thereby easing or removing asset tests.

Policy makers and advocates have identified the Medicare Savings Programs asset test as a substantial obstacle to Medicare Savings Programs participation. Unlike the Medicare Savings Programs incomes levels, which are adjusted for inflation annually, the asset levels have been static since 1989. For that reason, over time, the asset levels have become more restrictive, disqualifying many persons who meet the income limits because they have resources above allowable limits. Additionally, the laborious task of collecting documentation to verify the value of various resources poses a significant hurdle for many older individuals and persons with disabilities. The experiences of the study states illustrate the potential benefits of simplifying financial eligibility rules and issues affecting states' willingness to ease them.

- *The Medicare Savings Programs asset levels represent a major barrier to enrollment.* The case studies confirmed that the asset standard prevents the Medicare Savings Programs from reaching many low-income persons, whom the benefits were designed to assist. Officials believed the asset standard did not reflect the financial reality of many Medicare beneficiaries who qualified for the Medicare Savings Programs based on income. Stakeholders in study states reported that many older low-income persons would rather forgo benefits than spend their modest savings or "rainy day funds" to qualify. Parties also said that the onerous job of verifying the worth of various items, such as burial accounts, life insurance policies, bank accounts, and vehicles, deters or prevents many eligible persons from completing applications for assistance.

- *Eliminating or easing the asset test can enable more low-income Medicare beneficiaries to qualify for benefits.* For example, after finding that the amount of assets owned by income-eligible persons with excess resources was relatively modest and could be easily spent down to meet the asset limits, Arizona eliminated the Medicare Savings Programs asset test. Removing the asset test helped extend the benefit to beneficiaries who were needy, but reluctant to exhaust their small savings to qualify. Similarly, Connecticut eliminated the QI asset test, believing that it was too low for the target population. Officials pointed out that the asset test presented an even greater hurdle to persons with incomes in the upper Medicare Savings Programs-range. This was especially true in Connecticut, where persons with higher incomes qualify for the Medicare Savings Programs because of increased income disregards. Similarly, Minnesota increased the Medicare Savings Programs asset standards to $10,000 for individuals and $18,000 for couples after state tracking data demonstrated that the asset test was preventing many low-income persons who sought assistance with their medical costs from qualifying for the Medicare Savings Programs. Officials in these states found it difficult to gauge the precise effect of loosening the asset test because other policy changes

[22] SSA § 1902(r)(2); 42 CFR Sec. 435.1007.

and outreach efforts were occurring at the same time. Nevertheless, all of the states believed that the change played a significant role in achieving subsequent, impressive enrollment gains.

- *Eliminating the asset test can help simplify the enrollment process for beneficiaries and states, facilitate community-based application assistance, and reduce agency staff workload***.** The experience of Arizona, the only state to completely discard the asset test for the Medicare Savings Programs, highlighted this benefit. Officials noted that dropping the asset test alleviated staff workloads, eliminating the time-consuming process of verifying applicant resources. Additionally, removing the asset test spared applicants the onerous task of collecting numerous forms of documentation, which discouraged many persons from enrolling in the programs. Further, waiving the resource test and the numerous documentation requirements that had been associated with it made it easier for SHIPs and other community organizations to provide counseling and initial application screening to clients.

- *Eliminating the asset test may be relatively cost-neutral for states*. For example, Connecticut removed the asset level for the QI benefit because the benefit is fully funded by federal dollars and would not lead to additional costs for the state. Arizona abolished the Medicare Savings Programs asset test after determining that administrative expenditures related to documenting assets were roughly equivalent to the cost of additional persons qualifying for benefits.

- *The impetus for easing financial eligibility criterion can come from a variety of sources; in many states, agency officials sought to eliminate the asset test in conjunction with advocates.* In Arizona, for instance, a team of state Medicaid policy personnel endorsed the elimination of the asset test based on an analysis of Medicare Savings Programs application denials. Advocates had not requested the change. In Connecticut, Medicaid policy officials fought for the elimination of the QI asset test when the state's aggressive enrollment simplifications and outreach efforts failed to yield appreciable enrollment increases. As a recipient of a CMS outreach and partnership grant, Connecticut had agreed to increase its enrollment by four percent in 2001, and the state was intent on reaching its goal. Local advocates, who had consistently championed improvements in the Medicare Savings Programs, also motivated state officials. Finally, Minnesota's decision to increase the asset limit for the Medicare Savings Programs was shaped by the political will to promote enrollment in the new state pharmacy assistance program. Eligibility for the state pharmacy program was based on QMB and SLMB enrollment, and in 2000, enrollment was unexpectedly low. The State Unit on Aging supplied tracking data from its information and assistance line to demonstrate that the asset test was too low and needed to be increased to enable the drug benefit to reach more needy people.

- *In economic downturns, states may resist loosening financial eligibility criterion***.** For example, Indiana officials briefly considered eliminating the asset test but dismissed the idea, assuming that it would be too costly in light of Medicaid budget constraints. Similarly, Washington state Medicaid managers recommended dropping the asset test in 2001, but other Medicaid items in the budget took precedence. Likewise, Connecticut Medicaid officials

thought it unlikely that the state would remove the asset tests for the QMB and SLMB programs given the state constitutional spending cap and a looming state deficit.

Eliminating Estate Recovery Requirements

The fear of estate recovery has been named as a significant obstacle to increasing participation in the Medicare Savings Programs.[23] Federal law requires states to seek recovery for Medicaid payments for long-term care services and related hospital and prescription drug services from the estates of Medicaid beneficiaries age 55 and older. In these cases, states must also seek recovery for payments for Medicare premiums and cost sharing made under the Medicare Savings Programs. For people who have not received long-term care benefits from Medicaid, states are permitted, but not generally required, to seek recovery for Medicaid expenditures, including those for Medicare premiums and cost sharing.[24] To dispel reservations about applying for the Medicare Savings Programs, states can design their estate recovery plans to exempt low-income Medicare beneficiaries whose Medicaid assistance is limited to the payment of Medicare premiums and cost sharing. The case studies highlight the difficulties presented by estate recovery in states.

- *Fear of estate recovery often deters enrollment and undermines state efforts to promote increased Medicare Savings Programs participation.* Numerous parties in all of the study studies reported that misunderstanding about how estate recovery works is widespread, with eligible individuals declining to apply based on suspicions that receiving benefits will allow the state to immediately seize their homes. Even when people do understand how estate recovery works, they may resist enrolling in the Medicare Savings Programs because they want to preserve a small inheritance for their descendants. Officials and advocates in Connecticut, Indiana, and Minnesota, which conduct estate recovery for Medicare Savings Programs benefits even in cases when beneficiaries do not use Medicaid long-term care, indicated that fears about the practice were a primary deterrent to enrollment and undercut state efforts to ease enrollment procedures and promote greater awareness of the programs.

- *Even in states that do not use estate recovery for beneficiaries receiving only Medicare Savings Programs benefits, education is needed to dispel widespread misunderstanding and fears*. Though Arizona and Washington do not conduct estate recovery for the Medicare Savings Programs, many individuals know that estate recovery applies to other types of Medicaid (such as long-term care benefits) and thus assume that the Medicare Savings Programs and Medicaid work the same way. Confusion about the states' policies was

[23] GAO-99, *Variations 1999*.

[24] 42 U.S.C. 1396p(b). See CMS Medicaid Manual § 3810 (revised Jan 11, 2001). The CMS manual states "Low income Medicare beneficiaries, who are receiving assistance from Medicaid agencies in the payment of their Medicare copayments and/or deductibles, can be exempt from Medicaid estate recovery, at State option, because they are not entitled to, or receiving, any Medicaid mandatory services which are subject to recovery." Medicaid mandatory services include long-term care, such as nursing home and home and community-based services, as well as associated hospital and prescription drug treatment. For QMB and SLMB enrollees who are simultaneously entitled to full Medicaid benefits and thus Medicaid mandatory services, states "must include in your claim against the estate, medical assistance amounts expended for Medicare cost-sharing and /or Medicare premiums"

exacerbated in the past when applicants for Medicare Savings Programs were required to complete the combined public assistance or Medicaid applications that referred to the states' estate recovery programs. Advocates in Arizona recommended an extensive information campaign to allay estate recovery fears.

Enhancing the Medicare Savings Programs Benefit

The Medicare Savings Programs provide valuable assistance but do not include coverage for such essential health care services as prescription drugs and preventive care that many low-income older persons and individuals with disabilities need. Due to the limited nature of Medicare Savings Programs coverage, policy makers have speculated that many eligible persons may perceive that the value of the benefit fails to warrant the effort entailed in applying for the programs, especially when cumbersome enrollment procedures are involved.[25] Accordingly, improving the richness of the overall benefit package for persons in the Medicare Savings Programs-income range could help to persuade more persons to apply for benefits. States have a number of options to increase the level of assistance that persons who qualify for the Medicare Savings Programs can receive. Two notable strategies include extending full Medicaid eligibility to those with incomes up to the poverty level and linking the Medicare Savings Programs to a state pharmacy prescription drug program. Experiences from the study states demonstrate that these approaches are effective ways to increase Medicare Savings Programs participation.

- *Raising the Medicaid income eligibility limit to the poverty level can produce a concomitant increase in Medicare Savings Programs enrollment*. In 2001, Arizona and Minnesota increased the Medicaid income eligibility limit to the federal poverty level, making many QMBs eligible for full Medicaid benefits. State officials believed that the Medicaid benefits package, which includes prescription drugs and other non-Medicare-covered services, likely encouraged more persons to apply for assistance. Additionally, applicants found ineligible for Medicaid and QMB could qualify for the SLMB, QI-1 or QI-2 benefits.

- *Linking the Medicare Savings Programs benefit to state pharmacy assistance programs can help to increase Medicare Savings Programs enrollment.* Before Minnesota implemented its prescription drug program, it struggled with raising awareness of the Medicare Savings Programs. The state found that linking the Medicare Savings Programs to the state pharmacy assistance program made it easier to market the Medicare Savings Programs because a drug benefit is easier to grasp and has more resonance with the market. Also, as described above, the political will to increase enrollment in the drug program helped to achieve eligibility expansions for the Medicare Savings Programs because the programs were linked.

Streamlining and Facilitating Application, Enrollment and Renewal Processes

States can promote enrollment in the Medicare Savings Programs by making the application process and operation of the program more user-friendly and efficient. Such efforts not only

[25] See *Variations 1999; AARP 1999.*

help individuals navigate the application and renewals processes, but also ease many of the states' challenges in administering the programs. The experience and lessons of case study states in this area are summarized below. (See Table A for detail on specific states' activities in this area.)

Simplifying Application Forms and Procedures

Cumbersome enrollment processes have been identified as a leading obstacle to enrollment in the Medicare Savings Programs. Enrollment processes that entail lengthy, complicated forms, numerous documentation requirements, and personal interviews at local social services agencies deter and sometimes prevent eligible older persons and individuals with disabilities from applying for the Medicare Savings Programs. Policy makers and CMS have encouraged states to take a number of steps to ease the Medicare Savings Programs application process. Foremost among the recommendations is the adoption of a simplified, mail-in Medicare Savings Programs application form. In 1999, as part of its Government Performance Results Act initiative, CMS released a model application form for states that is two-pages (double-sided), uses fourteen point fonts, and includes adequate white space to enhance readability for persons with diminished sight (see Appendix C for a copy of the form). Translating Medicaid application forms into Spanish and other prevalent languages accommodates persons with Limited English Proficiency.

In conjunction with the shortened, mail-in forms, states can eliminate the need for an in-person interview and allow applicants to self-certify the veracity of their financial information, thereby eliminating most written documentation requirements. In 2001, CMS advised states that self-declarations can be accomplished without threatening program integrity, given the requirement that states verify financial eligibility information submitted by applicants independently through computer matches and data exchanges with other agencies. Additionally, states can engage in quality control pilots that will allow them to test simplifications without penalty.[26]

The experiences of the study states illustrate the issues involved in implementing streamlined applications and procedures.

- *Simplified application forms and processes are often more complicated than they appear and may require further refinement to eliminate barriers.* All of the study states adopted simplified Medicare Savings Programs application forms, which were uniformly lauded as an improvement over the traditional application process. However, advocates noted a number of problems with the new forms, including requirements to submit numerous documents to verify income and assets (i.e., pay stubs, bank and account and pension statements, burial funds, life insurance policies, vehicle registrations); the need for an in-person or telephone interview with an eligibility worker; requests for irrelevant information; the failure to translate applications into other languages; and crowded and hard-to-read formats. Some states had to once again revise their application processes to address these concerns.

- *States can eliminate documentation requirements without undermining program integrity.*

[26] Timothy Westmoreland, Director, Center for Medicaid and State Operations. Health Care Financing Administration, Letter to State Medicaid Director, January 19, 2001, 42 C.F.R §§ 435.930 - 435.965

Because documentation requirements were perceived as an obstacle to Medicare Savings Programs participation, most states eventually waived some or all verification requirements related to finances. For example, in Connecticut state officials waived income and asset documentation requirements, believing that automated collateral verification systems could detect most inaccuracies. The state had not observed an increase in errors or fraud since the change was made. Also based on this rationale, Washington waived all financial verifications, and Minnesota eliminated asset verifications.[27] In contrast, despite the availability of CMS grace periods to test simplifications, Indiana was reluctant to eliminate most verifications, believing that data exchange systems could not prevent errors.

- *Even when application forms and processes are streamlined, many older people require personalized help to apply for benefits*. Officials in the study states noted that a number of older people, especially those with low literacy, limited English-speaking skills, and cognitive impairments, found the application process too difficult to complete on their own. In all of the states, SHIPs provided Medicare Savings Programs counseling and application assistance to older applicants. Various parties believed that SHIPs were especially suited for this role because they lack an association with welfare programs, have substantial knowledge about Medicare and the Medicare Savings Programs, and are especially attuned to the needs of the Medicare population.

- *Differences of opinion exist regarding the best approach to application design.* In 2001, Arizona began phasing in a universal Medicaid application form that could be used for all forms of acute care Medicaid, including the Medicare Savings Programs and Medicaid for children and families. Although the universal form was somewhat longer and more complicated than the Medicare Savings Programs application form, the universal form facilitated enrollment for all household members on one form, eliminating the need for family members to submit separate applications and simplifying the job of outreach workers. Conversely, Minnesota initially used an 11-page universal Medicaid application form for Medicare Savings Programs applicants, but many older persons found it confusing and difficult to complete. For that reason, the state developed a shorter, "seniors-only" application that eliminated irrelevant questions (i.e., related to pregnancy) and used larger font and more white space. The state believed that the simplified application form would make a significant difference in the number of applications submitted, as well as the number that are completed correctly and lead to benefits.

- *Relying on community agencies and providers to help applicants enroll in the Medicare Savings Programs is a promising strategy, but pitfalls can stymie these efforts.* Study states have begun partnering with trusted community organizations to provide a less threatening and more convenient opportunity for individuals to apply for benefits. States like Arizona and Washington, which provided seed money and training to community organizations, believed that community-based application assistance was a helpful tool to reach out to underserved communities. On the other hand, Indiana's experience with alternate enrollment sites illustrates that lack of funding and intricate enrollment processes can undermine their effectiveness. The initial enthusiasm of enrollment center staff quickly dissipated as they

[27] Minnesota requires documentation of assets if liquid resources are within $300 of the asset limit.

confronted the difficulties involved in helping beneficiaries understand the complexities of the Medicare Savings Programs, fill out complicated forms, and gather multiple documents with personal financial information. What is more, many enrollment center representatives felt overburdened by their current full-time responsibilities and grew resentful of needing to take on an additional chore that required much paperwork and time, without funding or, at a minimum, reimbursement for expenses. Ultimately, enrollment centers generated very few applications, and many discontinued their participation.

Improving Medicaid Operations, Computer Systems, and Renewal Processes

Even when states adopt simplified mail-in application processes and provide community-based enrollment opportunities, Medicare Savings Programs eligibility processes are still highly dependent on traditional social services systems. This link makes the upkeep of the social services infrastructure a critical component in state efforts to boost enrollment in the Medicare Savings Programs. While states have much flexibility in how they design and administer their Medicaid and social services systems, federal law requires attention to multiple elements.

To start with, states are responsible for providing training and education to local social services offices so that personnel are knowledgeable about Medicare Savings Programs eligibility and enrollment procedures.[28] Second, federal law requires compliance with certain protocols to ensure that applications are processed with "reasonable promptness"[29] and that eligible persons get health care coverage. These requirements include processing applications and providing proper notice of determinations within 45 days of the date of application;[30] considering applicants for all full Medicaid and Medicare Savings Programs categories for which they may qualify, regardless of which program they apply for; and not terminating Medicaid benefits without first determining whether beneficiaries may still be eligible under another Medicaid coverage category.[31] This last issue commonly arises when states learn from the Social Security Administration that an applicant no longer qualifies for SSI (often based on improved financial circumstances) and thus cannot qualify for Medicaid on that basis. In these cases, states must explore other avenues for Medicaid eligibility, including the Medicare Savings Programs.[32]

Third, states are responsible for ensuring that their information management systems function properly so that benefits are received in a timely manner. Once persons are found eligible for the Medicare Savings Programs, their information must be transmitted between local, state, and federal computer systems to activate the increase in their Social Security check and the state's

[28] Centers for Medicare and Medicaid Services, *Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage*, 2001 [Hereafter *The Guide*].
[29] 42 U.S.C. § 1396a(a)(8).
[30] 42 C.F.R §§ 435.911, 435.930. It is especially critical that QMB applications are processed in a timely fashion because retroactive benefits are not allowed, and benefits can become effective only during the month following the month in which eligibility is determined. Even if there are no delays in the processing of an application, beneficiaries still may need to wait several months before they become entitled to benefits. For example, if an applicant submits a QMB application on January 31, the state has until March 17 to process the application, with benefits only effective on April 1. See Patricia Nemore, *Medicare/Medicaid Buy-In Programs: A Guide For Advocates*, National Senior Citizens Law Center, January 2000.
[31] *The Guide*.
[32] Also, persons may still qualify for Medicaid through a spend-down or if the state offers full Medicaid to persons who exceed the SSI financial eligibility criterion.

payment of their Medicare premiums. Problems that occur at any point along this path can cause lengthy delays in the receipt of benefits. States can help avoid problems for clients by ensuring that their computer systems are designed to interface well with federal databases.[33]

Finally, states must design their systems to redetermine or renew Medicare Savings Programs and Medicaid eligibility at least once annually. In conducting renewals, states are only permitted to ask about information that can change, such as income and assets. Seniors have indicated that renewal processes are difficult to complete, and Medicaid drop-off upon eligibility review has been identified as a significant problem for children and families.[34] To help eligible persons maintain benefits and improve enrollment rates in the Medicare Savings Programs, states have wide latitude to streamline renewal procedures. Fundamental steps include eliminating quarterly reviews and dispensing with in-person interviews and verification requirements. Additionally, states can adopt pre-printed renewal forms that show client information in the eligibility system and simply require the beneficiary to sign and return the form with indications if information has changed.[35] Alternatively, states can use a passive renewal process, directing the beneficiaries to return the form only if their circumstances have changed.[36]

The experiences of the study states illustrate important lessons about Medicare Savings Programs operational issues.

- *Given their critical role in the enrollment process, local eligibility workers need ongoing training and education about the Medicare Savings Programs to ensure that eligible applicants get covered.* Despite the use of mail-in applications and alternate enrollment sites, local field offices remain the primary point of contact for Medicare Savings Programs applicants in the study states. Experiences in the study states confirmed that simplification and outreach efforts can be stymied when eligibility workers and receptionists impart incorrect information to clients or fail to implement program improvements. To avoid these problems, state officials reported that they engaged in ongoing worker education activities, including on the job training, live and on-line instruction, automated help desks, refresher courses, and policy alerts. These efforts seem to have paid off in the study states given comments by advocates that eligibility workers had become more knowledgeable about the Medicare Savings Programs in recent years. Advocates recognized that the task of educating local offices posed special challenges for states in light of communication breakdowns between different levels of the bureaucracy, high staff turnover, and budget cuts.

- *Aligning Medicaid and Medicare Savings Programs enrollment processes can help ensure that eligible persons will not miss out on full Medicaid benefits*. Officials in all of the study states reported that eligibility workers and automated systems automatically screen persons

[33] Requirement for time of approval of benefit but no time line governing the length of time between approval for benefits and actual receipt of assistance.
[34] The Kaiser Commission on Medicaid and the Uninsured, *Barriers to Medicaid Enrollment for Low-Income Seniors: Focus Group Findings*, January 2002 [Hereafter *Barriers to Medicaid*]; *the Guide*.
[35] Federal law only permits states to inquire about information that may have changed, i.e., income and assets. States that use their initial application forms for yearly renewals are not complying with federal requirements. *The Guide.*
[36] *The Guide*. States using passive renewals must have procedures in place to determine if the beneficiary continues to reside in the state. Id.

for all forms of Medicaid when applicants use the traditional application process. The use of the short form in some states raised the question of whether persons who were eligible for full Medicaid benefits could be missing out on them by using the short form. For example, in Connecticut and Washington, the Medicare Savings Programs application form was not screened for full Medicaid eligibility. Applicants were advised to submit the traditional form if they wanted to apply for those benefits. One official voiced the concern that applicants may not understand the full range of coverage available and may thus unknowingly forgo benefits. In contrast, in states where application requirements were aligned for Medicaid and the Medicare Savings Programs, applicants were more assured of being considered for full Medicaid benefits. For example, in Arizona the Medicare Savings Programs and Medicaid program application was combined because both programs had dispensed with the asset test and the need for an in-person interview. Similarly, the elimination of asset verifications and an in-person interview requirement for both Minnesota's Medicaid program and the Medicare Savings Programs enabled the state to devise a "seniors-only" application form that included both benefits and to routinely screen all applications for the full range of coverage options.

- *Ongoing maintenance and revision to automated systems can help prevent inordinate delays in the receipt of Medicare Savings Programs benefits.* Experiences in the study states confirmed that computer problems can cause inordinate delays between the time applicants are approved for benefits and the time their Social Security checks are increased to reflect the state's payment of the Part B premium. Reasons for the delays included: incompatibility between the various computer systems; keystroke errors when the information is entered; or mismatches in information. Some states had made greater progress in managing these problems than others, but all recognized the importance of updating their state computer systems to avoid problems on their side.

- *Simplifying renewal procedures remains a challenge in the retention of Medicare Savings Programs beneficiaries.* The study states had generally focused their Medicare Savings Programs promotion efforts on simplifying the application and enrollment process and have paid less attention to streamlining the renewal processes. Renewal processes differed in all of the states. Common approaches were to have persons renew by completing the shortened Medicare Savings Programs application form or to have them complete a multiple page renewal form. Documentation requirements were common. State officials confirmed that some seniors failed to complete the renewal process, generally due to cognitive or physical impairments, a changed of address, or hospitalization. These individuals only realized that they had lost their benefits several months later, when they received a letter from the Social Security Administration and a reduction in their Social Security check. Given these difficulties, simplifying the renewal process may help prevent unnecessary interruptions and terminations in benefits. Some states, like Minnesota, were considering devising a renewal process that would entail the use of a pre-printed postcard that would need to be signed, amended with updated information, and returned to the state.

Outreach and Partnerships

States' efforts to improve eligibility and processes in the Medicare Savings Programs are only

useful if people know about the programs and apply for assistance. Many reports have identified lack of knowledge about the Medicare Savings Programs and inadequate outreach as primary reasons for under participation in the Medicare Savings Programs.[37] As such, states have undertaken various outreach initiatives to raise awareness of the availability of the programs. The experience and lessons of case study states in this area are summarized below. (See Table A for detail on specific states' activities in this area.)

Using Targeting Mailings

Targeted mailings have been identified as a potentially efficient means of raising awareness about the Medicare Savings Programs.[38] Mailings can be directed to a variety of audiences: recipients of other state low-income programs; newly eligible Medicare enrollees with Social Security incomes in the Medicare Savings Programs range culled from CMS leads data or internal Social Security lists; and low-income households contained in membership and commercial mailing lists.[39] The case studies demonstrate that direct mailings are an effective strategy when appropriately designed and well-targeted and also reveal important issues in designing and assessing these mailings.

- *Enrollees of state pharmacy assistance programs with financial eligibility criterion similar to the Medicare Savings Programs are especially good audiences for mailings.* In Connecticut, a direct mailing to state pharmacy assistance enrollees generated a 16 percent response. State officials reported that this population is very receptive to outreach because they are "generally on the edge financially, may have large medical bills, and are already familiar with public benefit programs."

- *Outside of state drug assistance programs, Social Security benefit records are more reliable than commercial mailing lists.* Among the study states, states using CMS leads data (names and addresses of newly eligible Medicare beneficiaries with Social Security incomes at or below the poverty level) experienced a reasonably good return rate from mailings. For example, in Indiana, about eleven percent of leads data mailing recipients over a 15 month period became enrolled in some form of Medicaid, with seven percent enrolled as QMBs. Additionally, in Indiana, mailings in the Social Security demonstration project generated a response rate of about 7 percent. In contrast, mailings to low-income older persons based on AARP membership and commercial mailing lists typically yielded about a one percent response.

- *Mailings involving collaborations between the Medicaid agency, the Social Security office, and the State Health Insurance Counseling Program may generate better results than those with just the Medicaid agency*. Because the Social Security Administration is highly trusted among older persons and does not carry a welfare stigma, officials in the case study states

[37] *Variations 1999; Families USA, AARP, GAO*
[38] GAO 1999, Variations 1999.
[39] Federal legislation has mandated that SSA provide all state Medicaid agencies "and any other appropriate State agency with information consisting of the name and address of individuals residing in the State that the Commissioner determines may be eligible for medical assistance for payment of Medicare cost-sharing . . ." Medicare, Medicaid and SCHIP Benefit Improvement Act of 2000 (BIPA), § 911.

thought that the use of Social Security letterhead helped to raise response rates. Furthermore, they reported that the involvement of Medicaid officials in preparing the mailing packets ensures that mailings accurately reflect the state's Medicare Savings Programs eligibility criterion. Finally, officials in the majority of the study states believed that publicizing the SHIP toll-free number to enable recipients to receive counseling and personalized application assistance made it more likely that eligible persons would complete the application process.

- *Beneficiaries are more likely to respond to materials that use catchy taglines, concise descriptions of what the benefit means in practice, and an attractive, easy-to-read design***.** In Minnesota, mailings to low-income Medicare beneficiaries initially generated a minimal response. After the letter was redesigned, county human services staff and the Senior LinkAge® Line noticed an appreciable increase in inquiries from mailing recipients. The letter catches the reader's attention with the tagline, "Important information for Medicare enrollees. Could you use an extra $500 each year?" The letter then explains the practical effect of enrolling in the Medicare Savings Programs, stating "Your Medicare premiums could be paid for you through special programs. If you qualify, your monthly Social Security check would increase by the amount you currently pay for premiums." Finally, the letter includes two colors and larger font, making it attractive and easy to read.

- *Direct mailings and other publicity campaigns can be useful even if they fail to generate large numbers of immediate responses because they help to augment other outreach and education efforts*. States that used mailings seemed to recognize that mailings were a useful tool in raising awareness about the Medicare Savings Programs and in reinforcing messages through repetition. Minnesota officials noted that persons may not actually apply for the Medicare Savings Programs until they hear the message from three to seven times, through a variety of sources.

Fostering Partnerships

Policymakers and the federal Government have recommended that states partner with federal agencies, State Health Insurance Assistance Programs, community groups, and Federally Qualified Health Centers to devise and implement effective methods to raise awareness about the Medicare Savings Programs and help persons enroll in the programs.[40] The case studies demonstrated the value of these collaborative relationships.

- *Partnering with local groups and established community providers is a key way to target under-served populations*. State officials in the case study states formed collaborative relationships with local advocates and service providers that were situated within and trusted by underserved populations. These relationships reflected a recognition that established community groups are best equipped to find and engage un-enrolled persons and to develop outreach strategies that coincide with the values, habits and experiences of target

[40] Timothy Westmoreland, Director, Center for Medicaid and State Operations. Health Care Financing Administration. State Medicaid Director Letter, December 4, 2000; Health Care Financing Administration, *Announcement: Building Partnerships for Innovative Outreach and Enrollment of Dual Eligibles,* April 2000; Marilyn Gaston, Bureau of Primary Health Care. Health Resources and Services Administration. Program Assistance Letter, December 2000; *GAO 1999*, *AARP 1999*, *Variations 1999*.

populations. For example, in Washington, community-based organizations and providers recognized that outreach to Filipino elders must engage and target adult children, who tend to be very involved in health care decisions for their parents. Additionally, local groups knew that Filipino elders needed specific advice about applying for the Medicare Savings Programs if they lacked sufficient work history to qualify for premium-free Part A; how their immigration status affected their eligibility; and how Medicare Savings Programs enrollment would affect their ability to sponsor over-seas relatives for immigration to the U.S. The local groups' knowledge of this population helped assure that outreach met the needs of the target population.

- *Collaborative relationships between state agencies and community based organizations and providers can be mutually beneficial.* By working with state agencies, local groups and providers in the study states obtained another tool to help their clients, access to technical assistance on problem cases, and, in most cases, seed money to help fund outreach efforts. The state organizations also benefited in that they could initiate a presence in the community and learn how to appropriately reach underserved populations. For example, the Medicaid agencies in Arizona, Connecticut and Washington began partnering with local health centers to conduct Medicare Savings Programs outreach. The partnerships help the state because health center personnel are often racially and ethnically diverse, attuned to the cultural norms of target populations, and fluent in Spanish and other languages. In addition, health centers come into contact with older clients living with extended family members who are health center patients and generally have experience in Medicaid outreach. At the same time, learning about the Medicare Savings Programs and conducting outreach helps the health centers by providing health care coverage for existing patients, promoting good community relations, and positioning them as multi-generational providers to meet the need of the aging baby boomer population.

- *Similarly, collaboration between aging agencies and Medicaid agencies strengthens the agencies' respective efforts to increase Medicare Savings Programs participation***.** Officials interviewed felt that partnering with SHIPs, Area Agencies on Aging, and State Units on Aging, which are well-established and trusted by Medicare beneficiaries, helps Medicaid agencies to distance the Medicare Savings Programs from negative welfare connotations, which officials in all states identified as a considerable deterrent to applying for the benefits. The case studies revealed that Medicaid agencies also benefit because SHIP staff and counselors are well versed in Medicare and the Medicare Savings Programs and are especially attuned to the needs of older persons. As such, SHIPs are well-suited to provide one-on-one counseling and assistance to applicants, thereby helping to alleviate the workload of caseworkers. Similarly, the Medicaid agencies help SHIPs by providing education and training about the Medicare Savings Programs and Medicaid and helping to trouble-shoot in problem cases and track the status of applications.

- *Effective outreach to under-served populations requires not only translations, but also recognition of the cultural norms and experiences of the target population*. In most of the study states, application forms and outreach materials were available in non-English languages (generally Spanish). States recognized, however, that translating forms and written materials were only the first steps to reaching minority populations. For that reason,

states began designing outreach interventions that were culturally appropriate for the target population. For example, in Arizona, state agencies obtained advance permission and support from tribal leaders and respected elders before conducting outreach on Indian Reservations. Additionally, state agencies teamed with tribal health care workers and professionals in order to dispel elders' misgivings about applying for government programs and provide face-to-face counseling using simple terms and the elder's Native language. Finally, outreach messages emphasized how receipt of Medicare and Medicaid would stretch limited health care dollars for the tribe and improve access to health care for elders. Similarly, as noted above, state officials in Washington teamed with local groups and recognized that outreach to Filipino elders needed to reflect their cultural values and experiences.

- *Outreach campaigns and streamlined enrollment procedures alone may not significantly increase Medicare Savings Programs enrollment; relaxing eligibility criterion and fixing systemic problems may also be needed.* To increase Medicare Savings Programs participation rates, Connecticut undertook numerous efforts in community outreach, simplification of the application process and organizational partnerships. Despite these efforts, participation rates remained relatively constant, indicating that a policy change was necessary. Once the state abolished the QI asset test, the state's continued outreach and enrollment efforts produced appreciable enrollment increases. Additionally, in all of the study states, the fear of estate recovery was a major deterrent to Medicare Savings Programs enrollment and undermined other state activities to promote the Medicare Savings Programs. Even when states exempted the Medicare Savings Programs from their estate recovery programs, widespread education was needed to dispel confusion and misunderstanding of the state's policy.

- *Increased involvement by the Social Security Administration in outreach and enrollment activities could improve participation in the Medicare Savings Programs.* Parties in the case study states uniformly concurred that participation by the Social Security Administration in activities to promote the Medicare Savings Programs would help to dispel negative welfare connotations about the Medicare Savings Programs. Officials suggested various options for SSA to help with enrollment, such as helping persons enroll when they initially apply for Medicare, including Medicare Savings Programs information along with persons' Social Security statements; and routinely disseminating SHIP materials to clients at local offices.

- *Tracking the effect of outreach interventions helps states to discover the most effective techniques and improve their outreach strategies.* Tracking important trends, such as the number of calls generated, amount of applications received, and the percentage of approvals and rejections, can help officials improve the efficiency and effectiveness of outreach strategies. For example, Minnesota's collection of data during an outreach campaign in subsidized housing sites allowed the state to measure the impact of the intervention and to analyze the reasons behind poor results. Because the state found that most of the residents, if eligible, were already enrolled in the programs, it concluded that public housing sites are not a promising venue for Medicare Savings Programs outreach and redirected outreach efforts to other venues.

- Federal support of state outreach activities through technical support and grant funds enables states to foster collaborative partnerships and to develop innovative outreach approaches specially targeted to under-served populations. All of the study states used CMS grant funding to test innovative outreach practices that could be replicated nationally. In particular, grant funds to state Medicaid agencies in Connecticut, Minnesota, and Washington enabled the agencies to build relationships with local groups, agencies, and providers to explore, develop and test the most effective techniques to enroll "hard-to-reach" populations. Additionally, CMS' monitoring efforts and encouragement of outreach efforts helped to motivate all of the study states to focus on Medicare Savings Programs activities.

- *Outreach interventions to younger beneficiaries with disabilities are less well-developed and require increased attention.* In the study states, most Medicare Savings Programs outreach and information is aimed at elderly Medicare beneficiaries. However, 13 percent of Medicare beneficiaries are under age 65 and qualify for Medicare based on a disability.[41] To date, little outreach recognizes that younger, disabled beneficiaries have unique characteristics that may need to be taken into consideration when developing outreach interventions.

Conclusion

The Medicare Savings Programs provide valuable financial assistance with Medicare costs for low-income Medicare beneficiaries. Although the programs hold the promise of promoting access to care for many vulnerable seniors who do not qualify for the full range of Medicaid benefits, they still fail to reach many eligible persons.

To expand participation in these programs, states have begun initiating promising outreach and enrollment strategies, including loosening eligibility criterion and enhancing the value of the benefit package; easing application requirements and enrollment procedures and engaging in upkeep of the Medicaid eligibility systems; and enhancing outreach efforts and fostering partnerships to reach underserved populations.

Recent enrollment gains in the study states reinforced the view that these practices can significantly boost participation in the Medicare Savings Programs. The case studies demonstrate common themes that have helped to advance enrollment in the most successful states.

- First, significant gains are achieved when Medicaid agencies' wholeheartedly embrace the goal of achieving greater use of the programs.

- Second, application simplifications and outreach alone will not increase enrollment; addressing systemic problems and loosening eligibility rules are critical to successful

[41] Marsha Gold and Stevens, Beth, *Informed Health Plan Choice for Vulnerable Subgroups of Medicare Beneficiaries* Mathematica Policy Research Inc., Monitoring Medicare+Choice Operational Insights, September 2001.

interventions. Estate recovery, restrictive financial eligibility criterion, and breakdowns in operational systems can stymie progress.

- Third, although time-consuming and labor-intensive, the use of tracking data to measure the relative effectiveness of outreach techniques is a crucial way for states to learn what does and does not work and to improve the efficiency and cost-effectiveness of future interventions.

- Fourth, reaching underserved populations requires a substantial state investment in cultivating relationships with state health insurance counseling programs, community groups, and local providers.

- Fifth, disappointing results from initial simplification and outreach efforts do not necessarily mean that such efforts are futile. Fine-tuning and redirecting these efforts can appreciably improve their effectiveness.

- Finally, active involvement by the federal government and local advocates plays a significant role in promoting greater use of the Medicare Savings Programs. Advocates can help motivate state activities through monitoring activities and suggestions for improvements. Activities by CMS, including monitoring state's efforts, setting enrollment goals, providing grant funds to states, holding trainings activities, and providing technical assistance, have been vital forces for improvements and change.

In sum, the case study states demonstrate that much progress has been made to improve the Medicare Savings Program. However, 40.5 percent of eligible persons remained unenrolled. Continued refinement of outreach and enrollment practices and sustained commitment by the federal government, states, policy makers, advocates, community providers and others is required so that the promise of the Medicare Savings Program can be fully realized.

Appendix A: List and Definition of Dual Eligibles*

This list describes the categories of individuals who, collectively, are known as "dual eligibles." Medicare has two basic components: Part A, which pays for hospitalization costs; and Part B, which pays for physician services, lab and x-ray services, durable medical equipment, and outpatient and other services. Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

1. Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB Only) - These individuals are entitled to Medicare Part A, have income of 100% federal poverty level (FPL) or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers. Federal financial participation (FFP) equals the Federal medical assistance percentage (FMAP).

2. QMBs with full Medicaid (QMB Plus) - These individuals are entitled to Medicare Part A, have income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits. FFP equals FMAP.

3. Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB Only) - These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. FFP equals FMAP.

4. SLMBs with full Medicaid (SLMB Plus) - These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not in exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits. FFP equals FMAP.

5. Qualified Disabled and Working Individuals (QDWIs) - These individuals lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only. FFP equals FMAP.

6. Qualifying Individuals (1) (QI-1s) - This group is effective 1/1/98 - 12/31/02. There is an annual cap on the amount of money available, which may limit the number of individuals in the group. These individuals are entitled to Medicare Part A, have income of at least 120% FPL, but less than 135% FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. The

federal government pays the entire cost. This benefit has been temporarily continued until Spring 2003.

7. Qualifying Individuals (2) (QI-2s) - This group is effective 1/1/98 - 12/31/02. There is an annual cap on the amount of money available, which may limit the number of individuals in the group. These individuals are entitled to Medicare Part A, have income of at least 135% FPL, but less than 175% FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays only a portion of their part B premiums ($2.23 in 1999). The federal government pays the entire cost. This benefit will terminate as of January 2003.

8. Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1, or QI-2) - These individuals are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as a QMB, SLMB, QDWI, QI-1, or QI-2. Typically, these individuals need to spend down to qualify for Medicaid or fall into a Medicaid eligibility poverty group that exceeds the limits listed above. Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and, within this limit, will only pay to the extent necessary to pay the beneficiary's Medicare cost-sharing liability. Payment by Medicaid of Medicare Part B premiums is a State option; however, states may not receive FFP for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B had they been enrolled. FFP equals FMAP.

* From www.cms.hhs.gov.

Appendix B: CMS GPRA Initiative*

In 1998, the Centers for Medicare and Medicaid Services announced a Government Performance and Results Act (GPRA) measure to "Improve Access to Care for Elderly and Disabled Medicare Beneficiaries Who Do Not Have Public or Private Supplemental Insurance." To address this goal, CMS focused on activities to identify and enroll eligible persons in the Medicare Savings Programs.

Enrollment goals and monitoring state efforts

In FY1999, CMS worked with state representatives to establish national and individual state baselines of potential and enrolled dual eligible populations and enrollment targets upon which future performance could be judged. Based on the Third Party Premium Billing File†, the GPRA team established the national baseline enrollment as of September 1998 to be 5,167,000. A 4% national enrollment target was set for FY2000, which was twice the natural growth rate of 2% per year. The FY2002 goal was a 4% aggregate enrollment increase for six states that received CMS outreach grants (CT, MD, MN, TX, and WA) and a 2% aggregate enrollment increase for other states. Both national goals were met. During the course of the 3-year initiative, enrollment for all dual eligibles increased 10%, from 5,167,000 in September 1998 to 5,688,183 in September 2001

In conjunction with the national enrollment goal, CMS monitored the enrollment growth of individual states to ensure they showed gains consistent with the national target or had implemented activities to increase dual eligible enrollment. As part of its monitoring efforts, CMS requested states submit quarterly reports about their outreach activities and efforts to simplify administration. CMS identified the highest performing states in the areas of outreach, partnership, application, and other variables.

CMS Grants to Promote the Medicare Savings Programs

- In FY 1999, CMS awarded a total of $500,000 to states for conducting targeted mailings and printing and disseminating shortened application forms and outreach materials to local beneficiary groups.
- In FY 2000, CMS awarded a contract to the National Association of Protection and Advocacy Systems to fund four one-year pilot projects in Georgia, Washington, Michigan and New York. The projects tested the use of an ombudsman to provide individual information, assistance, advocacy and systemic reforms regarding the Medicare Savings Programs.
- In September 2000, CMS awarded grants to the state Medicaid agencies in Connecticut, Maryland, Montana, Minnesota, Texas, and Washington to foster partnerships and innovative outreach and enrollment of dual eligibles. Grants ranged from $51-182,000 and totaled $950,000 in FY2001.
- In 1999 and 2001, CMS awarded grants to a total of 15 SHIPs to: (1) develop and test outreach Medicare Savings Programs strategies; (2) provide beneficiary education, information, and application assistance for the Medicare Savings Programs; and (3) in certain cases, to fund a CMS contractor to provide technical assistance related to Medicare Savings Programs outreach.

Other Activities

CMS also held regional training conferences and developed an outreach kit, other training manuals, and a dual eligibles webpage for states, SHIPs, and advocates.

* *The CMS Performance on the Government Performance and Results Act Measure to "Improve Access to Care for Elderly and Disabled Medicare Beneficiaries Who Do Not Have Public or Private Supplemental Coverage,"* Center for Medicaid and State Operations, Disabled and Elderly Health Program Group, the Centers for Medicare and Medicaid Services, April 15, 2002

† The GPRA team relied on the Medicare Third Party Premium Billing File ("the Buy-in File") seemed to set the state and national enrollment baselines. The CMS data includes Medicaid enrollees for whom the state pays the Medicare Part B premiums, but who are not classified as the Medicare Savings Program enrollees. Timothy Westmoreland, Director, Center for Medicaid and State Operations, Health Care Financing Administration, Letter to State Medicaid Directors, January 13, 20

Appendix C: CMS Model Application for Medicare Savings Programs for Beneficiaries

[State Name] Application for Medicare Savings Programs for Beneficiaries (Dual Eligibles)

1. INSTRUCTIONS:

These programs may help pay all or part of your Medicare costs. However, this is **NOT** an application for full Medicaid, cash assistance, or food stamps. If you want to apply for these programs, contact your county department of human services. This application **CAN** be used for a single person or a couple (self and spouse). Read the application carefully and follow all instructions given throughout the form.

1. Answer each question the best you can. Attach additional pages if needed.
2. Include copies of all documents. **Do not send original documents.**
3. **Sign and date the application.**
4. Mail the application to:

5. An interview in-person is not required for these Medicare Savings Programs.

AGENCY USE ONLY

Case No. _____

Date Received _____

Date Registered _____

Worker _____

2. PERSONAL INFORMATION:

Name (First, Middle Initial, Last)	**You may have a friend, relative, or someone else help you complete this application. If someone else is completing this form, provide the following information for the individual completing the form.**
Birthdate Sex Race Marital Status	
Social Security Number U.S. Citizen ☐Yes ☐No	Name (First, Middle Initial, Last)
Street Address	Street Address
City State Zip	City State Zip
Phone County	Phone
Nursing Facility (if applicable)	Relationship to Individual

3. INFORMATION ON SPOUSE: Complete this information even if not applying for spouse.

Spouse's Name	Birthdate	Sex	Race	U.S. Citizen	Social Security Number (Optional, if spouse is not applying.)
				☐Yes ☐No	
Address of Spouse if Different from Applicant:					
Are you applying for Medicare savings for your spouse, too? ☐Yes ☐No					

4. LIVING ARRANGEMENT: Check the one box (☐) that describes current living situation.

	Own Home	Renting	Nursing Facility	In Other's Home	Hospital	Other (example: shelter)
Self	☐	☐	Date Admitted:	☐	Date Admitted:	Describe:
Spouse	☐	☐	Date Admitted:	☐	Date Admitted:	Describe:

5. INCOME AND EARNINGS:

List all types of earnings and income that you or your spouse receive. List the income amount before deductions (such as taxes or insurance) are taken out. Include proof of all income (check stub, benefit letter, etc.), **do not send original documents**. Examples of income include:

* Social Security
* SSI
* Wages/ Self-Employment
* Railroad Retirement Benefits
* Veterans' Benefits
* Trust or Annuity Payments
* Pensions/ Retirement Benefits
* Rental Income
* Oil Royalties/ Mineral Rights

Who Receives Income (Name)?	Type of Income	Employer or Source of Income	Amount	How Often Received?	ID Number (if applicable)

6. RESOURCES:

Do you or your spouse own or co-own any of the following? Include any accounts or properties on which you or your spouse's name(s) appear. Include verification (such as **copies, not originals**, of past 3 bank statements, trust funds, etc.) of all resources.

Do you, or your spouse, have any of the following resources?

Checking account	☐Yes	☐No	Funeral plans/ burial arrangements	☐Yes	☐No
Savings account	☐Yes	☐No	Burial plots	☐Yes	☐No
Government bonds	☐Yes	☐No	Stocks and bonds	☐Yes	☐No
Trust funds	☐Yes	☐No	Certificate of Deposits	☐Yes	☐No
Savings Bonds	☐Yes	☐No	Other (e.g. IRAs, etc.)	☐Yes	☐No

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.

7. LIFE INSURANCE:

Do you, or your spouse, have a life insurance policy? ☐Yes ☐No

If yes, please complete the following information and attach a **copy** of the policy:

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

8. PROPERTY:

Do you own all or part of any real estate in which you do not live? ☐**Yes** ☐**No**

If yes, please complete the following for each piece of real estate and attach proof **(copies)** of ownership and current value. **Do not list the house in which you live.**

Address	Value	Amount Owed

Do you, or your spouse, own or co-own a car, truck, motorcycle, boat, trailer, or other vehicle? ☐**Yes** ☐**No**

If yes, please complete the following information about each vehicle:

Owner(s)	Year	Make	Model	Value	Amount Owed

9. INFORMATION ON MEDICARE:

Attach **copies** (front and back) of Medicare card(s) if you, or your spouse, have Medicare.

Do you have Medicare? ☐Yes ☐No	Type of Coverage **(Check Each Box that Applies)** ☐ Part A ☐ Part B	Effective Date	Medicare ID Number
Does your spouse have Medicare? ☐Yes ☐No	Type of Coverage **(Check Each Box that Applies)** ☐ Part A ☐ Part B	Effective Date	Medicare ID Number

10. INFORMATION ON OTHER INSURANCE:

Do you have other health insurance? ☐**Yes** ☐**No**

Does your spouse have other health insurance? ☐**Yes** ☐**No**

If you, or your spouse, have other insurance, please complete the following information and attach a **copy** (front and back) of insurance card(s):

	Health Insurance Company Name **and** Company Address	Annual Premium	Type of Coverage (Hospital, Medigap, RX)	Effective Date	ID Number
Self		$			
Spouse		$			

PRIVACY STATEMENT:

Federal and state laws and regulations limit the use and disclosure of confidential information concerning applicants and recipients of all agency programs to purposes directly related to the administration of these programs.

ASSIGNMENT OF RIGHTS OF PAYMENT FOR MEDICAL SUPPORT AND OTHER MEDICAL CARE:

(If you are applying on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described below, as a condition of his or her eligibility for the benefits covered by this application.) As a condition of my eligibility, I assign to the state any rights to medical support and to payment for medical care from any third party. I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days.

APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:

I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility by state and/or federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records. I also agree that my application authorizes these agencies to release to this agency the information needed to determine my eligibility. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which this agency may obtain the necessary proof.

I understand that each individual who receives assistance must provide or apply for a Social Security Number. I authorize the use of my (our) Social Security Number for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify eligibility for assistance.

I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I understand that I may request a fair hearing if I disagree with an agency decision in my case and that I may be represented by any person I choose.

I certify that I (or if filing for my spouse, my spouse and I) am a U.S. citizen, national, or alien in qualified alien status. If this application is being filed on behalf of another individual or individuals, the actual applicant(s) will need to make this certification.

APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:

State and federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I agree to notify this agency of changes in my income, resources, or living arrangements, which might affect my right to receive assistance.

Signature of Applicant or Representative:	**Date:**
Signature of Applicant's Spouse:	**Date:**

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