kaiser commission on medicaid and the uninsured

MEDICAID PROGRAMS TO ASSIST LOW-INCOME MEDICARE BENEFICIARIES: WORKING PAPER ON MEDICARE SAVINGS PROGRAMS IN CONNECTICUT

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

THE HENRY J. KAISER FAMILY FOUNDATION

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

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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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Introduction

In Connecticut, approximately 56.5 percent of individuals eligible for the Medicare Savings Programs are enrolled. Since 1999, the state has actively sought to extend the Medicare Savings Programs to more low-income Medicare residents in Connecticut and has employed multiple strategies to boost enrollment. The state has expanded financial eligibility for the programs, streamlined application and enrollment procedures, and undertaken numerous initiatives to reach out to eligible Medicare beneficiaries. These efforts hinged upon a shared commitment and partnership among the state Medicaid agency, the aging network, and advocacy groups to increase Medicare Savings Programs enrollment. Connecticut's multi-pronged approach has recently yielded significant gains in enrollment, with a nine percent increase from September 2000 to 2001.

Overview of Medicare Savings Programs Initiatives in Connecticut

Ease Financial Eligibility	· Income disregards of $183 (single) and $336 (couple) · No asset test for QI
Streamline & Facilitate Enrollment	· Mail-in, simplified application available on CT Legal Services website (in English and Spanish) · Self-certification of income & assets
Streamline & Facilitate Renewal	· No in-person interview or documentation at yearly renewal
Enhance Outreach & Partnering	· 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
Obstacles identified	· Asset test for QMB & SLMB · Fear of estate recovery · Welfare stigma · Potential for reduced access to providers for QMBs · Renewal process

This case study involved a site visit in Connecticut, with two days in Hartford and one day in Willimantic. Interviewees included officials from the Medicaid agency and the State Unit on Aging; staff and volunteers from CHOICES (the State Health Insurance Counseling Program (SHIP)); the Connecticut AARP Director; and attorneys from Greater Hartford Legal Services, Connecticut Legal Services, and the Center for Medicare Advocacy, Inc., a non-profit organization that provides education, advocacy, and legal assistance to help older persons and persons with disabilities receive necessary health care.

The case study begins with an explanation of the administrative structure of the Medicare Savings Programs network in Connecticut. It then describes Connecticut's Medicare Savings

Programs income and eligibility criterion and efforts to simplify and facilitate enrollment. The study continues with a discussion of outreach and partnership efforts and concludes with lessons from Connecticut about promoting Medicare Savings Programs enrollment.

Background

Characteristics of Connecticut and the United States

	Connecticut	United States
Total Population (2000-2001)[1]	3,374,256	279,972,786
Percent of Total Population Enrolled in Medicare (2000-2001)[2]	15.7%	13.5%
Percent of Medicare Population Below Poverty Level (2000-2001)[3]	10.3%	16.5%
Aged & Disabled Medicaid Income Eligibility Level for Full Benefits (2001)[4]	64% FPL	74% FPL (federal minimum)
Number Enrolled in Medicare Part B Buy-In Programs (2001)[5]	54,000	5,517,000
Growth Rate for Enrollment in Buy-In Programs (9/98 – 9/01)[6]	13.9% (7,192)	10.1%
Percent of Eligible Persons Enrolled in Buy-In Programs (2001)[7]	56.5%	59.5%

The Connecticut Department of Social Services is responsible for administering several publicly funded programs in the state, including the Medicaid program and financial and supportive services for older persons and individuals with disabilities. Two divisions within the Department of Social Services are involved with the Medicare Savings Programs. First, the Adult Services Division ("the Medicaid agency") has responsibility for administering financial and medical assistance programs for older persons and individuals with disabilities. The Medicaid agency develops policies and procedures, promulgates state regulations, and provides technical support and guidance to the regional the Department of Social Services offices ("public assistance offices") regarding Medicaid and the Medicare Savings Programs. Fifteen local public assistance offices located in five regional service areas process applications and determine eligibility for Medicaid programs, including the Medicare Savings Programs.

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

Second, the Elderly Services Division serves as the "State Unit on Aging" and plans, coordinates, funds and manages social, cultural, nutrition and health services for seniors. The Division coordinates with the Area Agencies on Aging and municipal agents for the elderly in 169 towns, which provide information and assistance to seniors and their families. The State Unit on Aging oversees the CHOICES program, the State Health Insurance Counseling Program (SHIP). The SHIP provides information and referral services for aging-related services in Connecticut, as well as counseling about Medicare, Medicaid, and other health insurance matters. The SHIP is administered locally by Area Agency on Aging staff and trained volunteers.[8]

State Outreach and Enrollment Practices

Financial Eligibility Criterion for the Medicare Savings Programs

Connecticut Medicaid & Medicare Savings Programs Financial Eligibility Rules

Full Medicaid Benefits (Aged, Blind, & Disabled)	• Income: 64% FPL • Assets: $1,600 single/$2,400 couple
Full Medicaid Benefits (Medically Needy Spend Down for Aged, Blind, & Disabled)	• Income: 64% FPL • Assets: $1,600 single/$2,400 couple
Medicare Savings Programs	• Income: Federal standards + $183 single/$336 couple disregard • Assets: $4,000 single/$6,000 couple for QMB and SLMB; no limit for QI programs • Estate Recovery: Included in state Medicaid plan

Income Eligibility

Connecticut uses a more generous methodology than the SSI program in counting monthly income for Medicare Savings Programs (as well as full Medicaid for the Aged, Blind, and Disabled Medicaid category). Whereas the SSI standards provide for an automatic $20 income exclusion from the gross income of a single person or couple applying for Medicare Savings Programs,[9] Connecticut rules call for the first $183 or $366 of unearned monthly income to be disregarded for a single person and a couple, respectively. Connecticut has employed a different income disregard from the SSI program since it started its Medicaid program in 1972. The amount of the income disregard has remained static since 1991 and is not indexed to inflation. Because of Connecticut's significant monthly unearned income disregard, eligibility for Medicare Savings Programs and Medicaid is expanded in the state, allowing for the inclusion of

[8] For the purposes of this study, the Elderly Services Division will be called the State Unit on Aging and the CHOICES program will be called the SHIP.

[9] In addition to the $20, SSI rules require states to disregard a portion of earned income, the first $65 of monthly earned income and one-half of the remaining monthly earned income received.

persons with more income than would be allowed in most other states.

Comparison of Income Eligibility Levels for Medicare Savings Programs in CT and the US

	2002 CT Medicare Savings Programs income Limits*	2002 Federal Medicare Savings Programs Income Limits**
QMB	$922 single/$1,361 couple	$759 single/$1,015 couple
SLMB	$1,069 single/$1,560 couple	$906 single/$1,214 couple
QI-1	$1,180 single/$1,709 couple	$1,017 single/$1,362 couple
QI-2	$1,476 single/$2,107 couple	$1,313 single/$1,762 couple

* Includes income standard income disregard of $183 for an individual and $336 for a couple

** Includes income disregard of $20.

Asset Limits

In the past, Connecticut used the state Medicaid statute's resource standard in assessing eligibility for all categories of the Medicare Savings Programs.[10] Effective April 2001, Connecticut eliminated the resource limit for the Qualified Individual Programs (QI-1 and QI-2). As a result, in Connecticut in 2002, a single person with an income up to $1,180 can qualify for the QI-1 program, whereby Medicaid pays the full Part B monthly premium, without regard to the person's resources. In addition, a person with monthly income up to $1,476 can qualify for the QI-2 program, whereby Medicaid pays a small portion of the Part B premium, without regard to a person's resources.[11]

Several factors influenced the state's decision to eliminate the asset test for the QI programs. At the outset, Medicaid officials believed that the current resource test, which is linked to the SSI rules, presented a significant obstacle to enrolling individuals in the Medicare Savings Programs. Officials noted that, whereas income levels for the Medicare Savings Programs are indexed to inflation, the asset levels are not and have been static over the years. Thus, many needy persons with incomes in the Medicare Savings Programs range had excess resources that prevented them from qualifying for the programs. Officials also pointed out that the asset test presented an even greater hurdle for people 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 the increased income disregards.

Second, since 1999, the state had aggressively pursued Medicare Savings Programs enrollment simplifications and outreach, but these efforts seemed to have little positive impact on the participation rate in the Medicare Savings Programs. This confirmed the belief of the Department of Social Services officials that a change in eligibility requirements might be required to meaningfully boost enrollment.

Third, actions by third parties helped motivate the state's efforts. For example, local advocates had testified in the state legislature and had written several letters to the Medicaid Commissioner

[10] CT has slightly more generous disregards than SSI for counting resources with respect to burial accounts and funds and life insurance.

[11] If the person has earned income, in addition to unearned, they may be able to qualify with higher gross income amounts.

about the need to implement changes to increase participation in the Medicare Savings Programs. Similarly, under its Government Performance and Review Act (GPRA) initiative, the federal Centers for Medicare and Medicaid Services (CMS) was encouraging states to ease enrollment and was monitoring state enrollment rates. Because Connecticut had recently been awarded a CMS outreach and partnership grant, the federal agency would be monitoring the state's enrollment increases during the grant term very closely.

Finally, like all states, Connecticut had an incentive to maximize the number of enrollees in the QI programs because, unlike the QMB and SLMB programs, where the state needed to match federal money, the costs of the QI benefits were paid for by federal funds. The QI benefits were paid from annual federal allocations made to states to pay for all or a portion of the part B premiums; the only cost to states was for administrative expenses, which the federal government reimburses at a 50 percent rate, as with other administrative Medicaid costs. Operational costs for the benefit were minimal and were offset by the infusion of federal funds in the state's economy. Further, any federal QI funds left unspent at the end of the year could not be carried over to the next and had to be returned by the state to the federal government.

Since the QI programs began in 1998, Connecticut had consistently been unable to use more than a small portion of the annual federal allotments, despite its increasing efforts to boost enrollment in the Medicare Savings Programs. For example, in 1998, Connecticut received more than $2.8 million for the QI program, but at the end of the year, less than $200,000 of the grant funds had been spent, with fewer than 400 persons enrolled in the QI programs. Similarly, in 1999, Connecticut received $2,942,000 in QI funds, but had only enrolled 611 persons at the close of the year. The state's $2,967,000 QI allocation in 2000 could have provided benefits to approximately 5,400 persons, but as of September 2000, only about 1,000 persons were enrolled in the QI programs (704 in QI-1, 344 in QI-2), leaving approximately $2.5 million to revert to the federal government at the end of the year. The 2001 QI allotment was to increase to $4 million, and Medicaid staff were skeptical that outreach efforts alone would lead to substantial inroads in using the money.

In fall 2000, Medicaid staff recommended eliminating the asset test for the QI programs. Staff limited their recommendation to the QI programs, as dropping the asset test for the QI programs, which are capped and fully funded by federal funds, would be relatively cost-neutral to the state. In contrast, staff thought it less likely that Connecticut would find it financially feasible to eliminate the asset test for all the Medicare Savings Programs, particularly in light of the State Constitutional spending cap and a looming state deficit. The change was approved and the Department of Social Services created a special account for the QI funds, outside the line-item budget, to avoid problems with the spending cap. In the wake of the change, the Medicaid agency, in collaboration with AARP, conducted mailings to state pharmacy benefit recipients and low-income seniors throughout the state. The eligibility expansion, in concert with the targeted outreach, generated a marked increase in enrollment in the QI programs; participation increased from 1,270 in March 2000 to 3,325 in June, 2001.

Estate recovery

Connecticut includes benefits received under the Medicare Savings Programs in its estate

recovery program, even though the federal government does not require states to do so when Medicare Savings Programs enrollees do not also use Medicaid long-term care benefits. The four-page Medicare Savings Programs application contains a brief discussion of the state's entitlement to recover Medicaid expenditures from a person's estate.

All parties interviewed commented that estate recovery presents a significant barrier to enrollment in the Medicare Savings Programs in Connecticut. Many parties believe that eligible persons choose to forgo benefits based on the incorrect belief that enrolling in the Medicare Savings Programs would entitle the state to confiscate their home and force them to leave it, or the desire to leave their home or small estate to their heirs when they die. Persons interviewed did not expect Connecticut to change its estate recovery policy for the Medicare Savings Programs in the near future.

Other Medicaid Rules Affecting MSP Enrollment

Through their outreach efforts in 1999 and 2000, Medicaid officials, SHIP staff and volunteers, and advocates identified system issues that impeded their outreach. Two commonly mentioned issues were the asset test and estate recovery, as noted above. Interviewees also noted other issues related to the design of the Medicaid program in Connecticut.

First, many persons worried that the value of the QMB benefit was being eroded in Connecticut because of reductions in state payments to QMB providers. In the past, a significant benefit of QMB was that it enabled persons to afford Medicare Part B, which assured wide access to providers. By enrolling as a dual eligible, rather than enrolling only in Medicaid, beneficiaries gained access to providers who may not participate in Medicaid because of the program's low payment rates. A 1997 federal law, however, permitted states to reduce the amount paid for cost sharing to providers serving QMB patients. In many instances, states can altogether forgo paying the 20 percent co-insurance to physicians who serve QMB patients. Providers may not collect the co-coinsurance from QMBs and must accept the 80 percent Medicare reimbursement as payment in full. The state and SHIP staff suspect that some providers are declining to serve QMBs because of the reduced reimbursements. Additionally, advocates are worried that if Medicare reimbursements fall, providers would become even more reluctant to serve QMBs.

Second, many interviewees noted that the QMB benefit does not include coverage for prescription drugs, unlike full Medicaid. Thus, in some cases, it is more beneficial for individuals with high drug costs to pay the Part B premium themselves and apply the $54 (in 2002) to their Medicaid spend-down to qualify for Medicaid. While these individuals gain access to the services they need, they have to go through frequent redeterminations and spend-down periods to retain these benefits.

Simplification and Facilitation of the Application Process

Application Form

In the past, all applicants for Medicaid benefits, including the Medicare Savings Programs, were required to complete a 14-page Medicaid application and to submit documentation of income

and assets. No in-person interview at the local public assistance office was required; the applications were generally processed through the mail.

Effective October 1, 1999, the Medicaid agency implemented a separate, simplified application form for the Medicare Savings Programs. The state had initially refrained from adopting a shortened Medicare Savings Programs form based on the concern that a short form would preclude persons from being considered for more generous levels of assistance, such as full Medicaid benefits. Despite these reservations, officials agreed to devise a shortened application for the Medicare Savings Programs in 1999 due to requests from legal services advocates and legislators to adopt a shortened form, as well as CMS' encouragement for states to adopt shortened forms. In the end, state officials wanted to demonstrate their commitment to promoting enrollment in the programs and were willing to test their assumptions and try new techniques to improve participation in the Medicare Savings Programs.

The shortened application was four pages, (two double-sided pages) and is based in large part on the CMS model application for Medicare Savings Programs. The form is available in English and Spanish versions, as well as in alternative formats for persons with disabilities.

Notably, the form waives the requirement that persons submit asset and income verifications. Instead, applicants or their representatives must sign a declaration under the penalty of perjury as to the veracity of information submitted. State officials agreed to institute self-declaration based on indications by CMS, national policy makers, and local advocates that documentation requirements were a major hurdle for many applicants. Although state officials had some concern about fraud or errors occurring as a result of self-verification, they believed that most discrepancies would be detected through the state's automated collateral verification system. Medicaid officials had seen no evidence to indicate self-declaration has led to errors or fraud since verifications were waived.

Persons could obtain the Medicare Savings Programs application through a variety of sources, including:

- Local social service offices, which mailed the form to callers along with a brochure and postage-paid return envelope;
- Local AAAs and the SHIP hotline;
- The Connecticut Legal Services Elder Law website; and
- Various community partners, including adult day centers, senior centers, municipal agents, home health agencies, hospital social workers, discharge planners, and legal services offices.

At the time of the case study, the state was exploring but has not yet developed the capacity to submit online applications.

Response to the shortened application form was overwhelmingly positive. Advocates remarked that the short form was much less burdensome than the long form and said they had encountered fewer eligible but un-enrolled clients since the form's implementation. SHIP counselors, Area Agency on Aging staff, and the State Unit on Aging generally believed that the application was much more user-friendly and that the elimination of the verification requirements had been helpful.

Training and Knowledge of Local Public Assistance Offices

In general, advocates interviewed did not believe that local public assistance office discouraged greater enrollment in the Medicare Savings Programs. Advocates observed that field staff had become more knowledgeable about the programs over time. On the occasions when issues did arise, Medicaid officials responded promptly to rectify them and issued guidance in the event of a widespread problem.

Cognizant of the importance of keeping front-line workers up-to-date, the Medicaid agency engaged in several training and education initiatives, including:

- Live and computer-based training with the involvement of Medicaid policy staff, as well as the SHIP program;
- Policy transmittals containing new and revised policy;
- Internal e-mail communications for additional guidance and interpretation on policy topics;
- An "internal bulletin board" for local workers to post questions to the Medicaid policy staff;
- Internal and external Department of Social Services newsletters; and
- Regular meetings of central and regional office managers.

Out-stationed Outreach and Enrollment Workers

Connecticut has out-stationed outreach and enrollment workers at Federally Qualified Health Centers throughout the state. The workers are funded by the Department of Social Services, the Health Resources and Services Administration, and the health centers. They are responsible for community outreach and Medicaid application assistance. Until recently, eligibility workers' efforts had generally focused on Medicaid for pregnant women, children, and families. As described in the Partnerships and Outreach section below, Connecticut's CMS Outreach grant has expanded the role of health center workers to focus on the Medicare Savings Programs and Medicaid for the elderly.

Computer Issues

The Department of Social Services has trained its staff and programmed its computer system to consider eligibility for all categories of Medicaid the person might qualify for upon receipt of the agency's "regular" 14-page multi-program application. Thus, if an individual submits a standard application form, the applicant is considered for all potential Medicaid coverage groups, including the Medicare Savings Programs. However, if an applicant submits the shortened Medicare Savings Programs application, the individual is not considered for any other programs. For that reason, the shortened application form states that applicants interested in other programs must file a separate application. This extra step, the Medicaid Agency believed, was the trade-off in adopting the shorter form.

In addition, if the Department of Social Services identifies a Medicaid beneficiary who is not enrolled in the Medicare Savings Programs despite eligibility for the programs, the Department

will provide retroactive QMB benefits to the date of enrollee's initial Medicaid eligibility. Finally, when information from the Social Security Administration indicates that someone has lost eligibility for SSI, Connecticut's computer system sends an alert to the local field worker to evaluate the enrollee for other categories of Medicaid for which they may still be eligible.

Advocates did not view the state's computer database as a barrier to the receipt of benefits. Some recalled that inappropriate terminations or delays due to computer problems had occurred several years ago, but once the state rectified the underlying issue, the problems abated.

Redetermination Procedures

Currently, the Department of Social Services sends out a shortened Medicare Savings Programs application form at the yearly renewal. The renewal form is essentially the simplified application form, with the title "Application/Redetermination Form." It allows for self-certification and does not require an in-person interview. According to the Department of Social Services, because of an oversight, a shortened redetermination form was not originally developed when the Medicare Savings Programs shortened application was devised. When the Department of Social Services discovered that enrollees were receiving the 14-page form at redetermination, it implemented the new procedure.

In the past, the Department of Social Services had considered implementing a passive re-determination process for stable cases within certain coverage groups, including Medicare Savings Programs. However, the agency had been advised by the regional CMS office that the practice was not permissible; the enrollee needed to sign and return a form upon renewal, even if there was no change in circumstances. The Department of Social Services now understands that passive renewals are permissible, but has no current plans to change procedures at the current time, as other information system projects have higher priority. Further, the Department of Social Services believes that the shortened renewal form is simple for clients and is not causing problems for enrollees. Advocates indicated that they had not recently seen instances of terminations for failure to complete the renewal process, but indicated that they had no way of knowing if this problem exists.

Outreach and Partnerships

In 1999, the Department of Social Services launched an outreach campaign to promote greater enrollment in the Medicare Savings Programs. Various factors motivated the state to undertake these initiatives, including: (1) the state's desire to increase enrollment, experiment with recommended practices, and demonstrate its commitment to serving vulnerable seniors; (2) requests from legal advocacy groups and the legislature to enhance participation in the programs; and (3) CMS activities to encourage Medicare Savings Programs enrollment and facilitate outreach.

In developing its outreach plan, the Department of Social Services recognized that "welfare" carried negative connotations for many persons and that, as the welfare agency, the Department of Social Services sometimes lacked the trust needed to encourage persons to enroll in the Medicare Savings Programs. Officials believed that to better market the Medicare Savings

Programs, it needed to involve local agencies and organizations, such as the Area Agencies on Aging, SHIP counselors, the AARP, and other advocacy organizations. These partners did not invoke the "welfare stigma" and had already built relationships and trust with Medicare consumers. One Medicaid official viewed these partners as her "passport" to the community.

In concert with its community partners, the Medicaid Agency implemented a multi-prong Medicare Savings Programs outreach plan. A CMS outreach grant in 2000 enabled the agency to enhance these outreach efforts. The agency refined its outreach techniques over time based on lessons learned.

Mailing Simplified Applications to Community Agencies and Professionals

Upon the release of its new Medicare Savings Programs application and brochure in October 1999, the Medicaid agency used CMS funds to mass-produce the application and brochure so that it could disseminate them to community partners around the state. The Agency mailed more than 22,000 sets of materials to 525 organizations, including Connecticut Area Agencies on Aging, senior centers, municipal agents for seniors, home health agencies, hospital social workers and discharge planners, and legal services offices. The Medicaid agency coded the applications and included a postage-paid, self-addressed envelope for tracking purposes. The mailing was intended to ensure that the materials would be quickly disseminated and widely available through a variety of sources. In addition, the state hoped it would highlight which community partners were best-equipped to generate applications.

The Medicaid Agency had expected the mailing to generate an initial flood of applications, but the flow of applications was gradual and sustained over time. During the first eight months of the mailing, the Department of Social Services received about 430 applications. As of January 2001, the Department of Social Services reported that it was still receiving about 30 coded applications per month, with 600 total applications received by that time. Most of the applications received by the Department of Social Services originated from the Area Agencies on Aging, municipal agents, and senior centers.

Use of CMS Leads Data

In January 2000, the Medicaid Agency began obtaining monthly CMS data that identified newly eligible Medicare enrollees with Social Security incomes at or below the federal poverty level. The agency used the information to send targeted outreach mailings and to identify Medicaid recipients who were eligible for the Medicare Savings Programs.

Upon receiving the file each month, the Medicaid reviews the data and takes the following steps:

- For persons who are not enrolled in any Department of Social Services programs or who are enrolled in Food Stamps only, the Department of Social Services mails an application packet that contains: (1) a bilingual letter describing the programs, how to apply for them, and the availability of the SHIP program to answer questions about the program; (2) a shortened application form; (3) a Medicare Savings Programs brochure; and (4) and a postage-paid return envelope addressed to the local Department of Social Services office.

- For persons with Medicaid (or with pending applications), but not enrolled in a Medicare Savings Programs program, a different bilingual letter is mailed. That letter simply advises the recipient about the Medicare Savings Programs and informs them that no application is necessary to apply. Recipients are told to contact their local caseworker or to call the SHIP if they have any questions. At the same time, a worker report is generated, instructing the eligibility worker to process the individual for the Medicare Savings Programs, as appropriate.

The Department of Social Services generally receives about 750 new leads per month and sends out about 550 application sets. It does not track the number of applications received through the leads mailings, but believes that it is a relatively cost-effective means of generating new applicants for the programs. The Department of Social Services officials believe the data would be even more useful to the state, however, if the file were expanded to include newly eligible Medicare beneficiaries up to the QI-1 limit (135 percent FPL) rather than just the QMB limit (100 percent FPL).

Presentations to Medicare Beneficiaries and Caregivers and Training for Professionals

Before 1999, Medicaid officials had routinely presented Medicare Savings Programs information to audiences of potentially eligible individuals and their caregivers. The presentations took place at locations such as senior centers, civic groups, and veterans organizations. Many of these presentations involved collaboration with the SHIPs, which delivered weekly Medicare presentations throughout the state that included information about the Medicare Savings Programs. Following the launch of its Medicare Savings Programs outreach campaign, the Medicaid Agency continued these consumer education activities in partnership with the SHIP.

Additionally, the Medicaid Agency began educating local services providers about the Medicare Savings Programs based on the idea that such professionals are well-situated to disseminate Medicare Savings Programs information and provide referrals. For example, in 2000, the Medicaid Agency partnered with the Center for Medicare Advocacy, Inc. and SHIP programs in Southwest and North Central Connecticut to provide day-long Medicare Savings Programs trainings to outreach workers, social workers, municipal agents, home health agency staff, resident services coordinators, and other professionals. The trainings received positive reviews from the participants.

Outreach in Low-income Housing Complexes

In April 2000, Medicaid officials participated in a "Medicare on the Road" 10-day event in the city of Hartford. The event was a partnership between the Medicaid Agency, AARP, Medicare contractors, and the Medicare Fraud and Abuse Program and aimed to educate low-income beneficiaries in elderly housing complexes and other venues about Medicare and the Medicare Savings Programs. Partners displayed information and answered questions at the outreach site, and applications were coded to track the results of the project. Contrary to expectations, only six Medicare Savings Programs applications were generated from this extensive outreach initiative.

Based on the initiative, Medicaid staff concluded that public housing sites are not a promising venue for Medicare Savings Programs outreach. If eligible for the programs, most senior housing residents tended to be already enrolled. Generally, people not enrolled had excess resources or were unlikely to participate in health fairs or other communal events ("shut-ins").

AARP and Local Area Agency on Aging Direct Mail to Beneficiaries

In April 2000, the Department of Social Services, AARP (national and local), and the North Central Agency on Aging in the Hartford area partnered in a direct mail campaign to promote enrollment in the Medicare Savings Programs. AARP mailed approximately 20,000 letters to households with individuals age 65 and older and incomes up to 200 percent of poverty. AARP used an internal membership list and a commercial, direct mail list to select the addressees.

Two different mailing strategies were employed: half of the letters contained a "bounce-back card," which the person could mail to the AAA for more information and an application, and half contained the Medicare Savings Programs short form application.

Both sets of mailings contained English and Spanish versions of a letter about the Medicare Savings Programs on AARP letterhead. Volunteers trained and recruited by AARP were available at the AAA to answer questions about the programs and the application form through a special hotline number. All applications were coded for tracking purposes.

The Department of Social Services had set a goal of receiving approximately 500 applications (2.5 percent of the mailing), but ultimately only obtained 324 (1.6 percent). Of the 324 applications generated, 197 were from people whose letters included the application and 127 were from those who received bounce-back cards. AARP and the state attributed the low response rate, in part, to the restrictive asset test. Additionally, as discussed below, the state later concluded that the commercial mailing lists are less likely to produce responses than other data sources.

CMS Grant

In July 2000, CMS awarded the Department of Social Services a grant to enhance its existing partnerships and develop new partnerships to conduct innovative outreach interventions. The Department's outreach plan under the grant was designed based on lessons learned from the prior outreach as well as recommendations by CMS, the General Accounting office, and policy makers regarding innovative ways to reach vulnerable elders and people who are less likely to enroll in the programs. Targeted populations for the grant included: African-American beneficiaries; Hispanic beneficiaries; individuals who are homebound and living alone; and white homeowners with higher education levels in relatively better health.

<u>Direct Mail Initiatives</u>

The Department of Social Services chose to conduct targeted mailings, in partnership with AARP and local SHIP programs, to enrollees in the ConnPACE program (the Connecticut pharmacy assistance program) and households in regions that were not included in the prior

AARP mailing. Pharmacy assistance beneficiaries were chosen as a target audience because the eligibility criterion for the pharmacy program is similar to that of the Medicare Savings Programs in Connecticut. [In 2001, the pharmacy assistance income limit was $15,100 and $18,100 per year for a single person and couple, respectively; there was no asset limit.] Based on Connecticut's expanded income limit for the Medicare Savings Programs, a person eligible for the pharmacy benefit would also be eligible for the Medicare Savings Programs, as long as the asset guidelines were met. State officials expected to begin the mailings after the Department of Social Services approved the removal of the asset test for the QI programs.

The mailing packets included: a one-page, bilingual letter from AARP; a Medicare Savings Programs brochure that reflected the elimination of the QI asset test; a coded short form application; and a postage-paid envelope addressed to the Medicaid Agency. The letters included the SHIP toll-free number for applicants to call for more information about the programs.

Results of Direct Mail Initiatives in Connecticut

	2000 AARP mailing	State pharmacy assistance mailing	2001 AARP mailing	Total
Number of applications mailed	20,000	30,000	36,000	86,000
Number of applications received	324 (1.6 % of mailing)	4,800 (16% of mailing)	375 (1% of mailing)	5,499

As indicated by the above chart, the mailing to the state pharmacy assistance recipients was significantly more successful than the AARP mailings, generating nearly 15 times more applications. Based on the results, Department of Social Services officials concluded that the pharmacy program recipients are a very receptive target population for Medicare Savings Programs outreach; they are, according to officials in the state, "very much on the cusp financially, have some familiarity with benefit programs, and are seeking ways to help their meet their medical costs." Second, the dramatically different results between the two mailings, which contained identical items, demonstrated that the targeted population can be as important as the benefit package itself. Third, the agency indicated that the large enrollment increase after the mailings indicated that many persons who applied were approved for benefits. Officials believed that the removal of the QI-1 asset test enabled many persons to qualify; if applicants had excess resources for the QMB or SLMB program, they could still qualify for the QI benefits.

Further, although the second AARP mailing generated fewer applications than the state pharmacy assistance mailing, Medicaid officials did not completely dismiss the use of targeted mailings based solely on income information. Officials explained that the AARP mailing immediately followed the state pharmacy mailing and coincided with a large outreach campaign coordinated by a local HMO. The state believes that, in certain respects, "the market was somewhat saturated by the time of the AARP mailing." Similarly, state officials learned the need to stagger targeted mailings to avoid overwhelming eligibility staff, many of whom worked overtime to comply with statutory deadlines for processing applications. Finally, the state observed that commercial mailing lists may not be the most reliable means of targeting Medicare Savings Programs eligibles. The Medicaid Agency said that information from the Social

Security Administration, for example, could better target low-income persons for benefit programs because the information may be more precise.

Training Professionals and Community Workers

In March and April 2001, the Medicaid Agency, the Center for Medicare Advocacy, and SHIP staff continued their efforts to educate professionals about the Medicare Savings Programs, training a total of 178 local professionals who work with low-income Medicare beneficiaries.

Attendees included SHIP counselors, municipal agents, community health center outreach workers, social workers, caseworkers, home care workers, home health agency staff, senior center directors, housing resident service coordinators, AAA staff, and adult day care center staff. The local Areas Agencies on Aging and the community health centers helped to recruit the participants.

The day-long trainings included an overview of Medicare and Medicaid; an explanation of the Medicare Savings Programs; information on the application process; and techniques to reach under-served populations. The number of applications generated by the training was not possible to assess, but an indicator of the success was that all of the completed evaluations rated the trainings positively.

Expanding the Role of Out-stationed Medicaid Workers

Under the CMS grant, the Department of Social Services aimed to increase the capacity of eligibility and outreach workers in Federally Qualified Health Centers to assist beneficiaries with Medicare Savings Programs applications and to conduct community outreach to promote awareness of the programs. As of June 2000, about six percent of the patients served by the state health centers were elderly, but health centers often came into contact with grandparents when they accompanied grandchildren to appointments.

Health centers were eager to build their elderly patient base so that they could serve entire extended families, gain Medicaid and Medicare reimbursements, and prepare to meet the needs of a growing elderly population.

Under the initiative, the Medicaid Agency partnered with the Connecticut Primary Health Association to arrange for designated outreach workers to attend the Medicare Savings Programs trainings for professionals (mentioned above), to prepare outreach plans to promote the Medicare Savings Programs in surrounding communities, to implement efforts according to plan, and to track applications generated by workers.

Although the results of the health center outreach efforts were still forthcoming at the time of this case study, all the parties involved believed that health centers were a promising site for Medicare Savings Programs outreach and enrollment activities.

Outreach to Churches and Places of Worship

Based upon recommendations by CMS and research about reaching under-served populations, the Department of Social Services decided to partner with religious institutions to identify homebound persons living alone who do not visit or live in places where outreach activities generally occur and Hispanic and African-American eligible persons. Through the intervention, the Department of Social Services and the AAA sought to: (1) recruit SHIP volunteers from the congregation; (2) obtain permission to conduct Medicare Savings Programs presentations and provide application assistance at churches; and (3) develop long-term relationships between churches and the SHIP programs.

In April 2001, the local Area Agency on Aging sent letters to 400 places of worship in the Greater Hartford region. The Agency made 100 follow-up calls, of which 43 requested additional information and none were interested in a presentation or visit on-site. Most churches responded that they were not the appropriate venue or indicated that they were already familiar with SHIP and would call in the future if necessary.

The Department of Social Services has not dismissed the concept of partnering with places of worship to promote the Medicare Savings Programs. Staff commented that the mailing and phone follow-up constituted the first steps in initiating ties with churches and are reviewing how to build on these initial steps.

Lessons Learned from Connecticut

- **The asset test can prevent needy Medicare beneficiaries from obtaining assistance through the Medicare Savings Programs.** Connecticut Medicaid officials attributed the failure of initial outreach and simplification efforts to yield appreciable enrollment increases in part to the asset test. Officials noted that, whereas income levels for the Medicare Savings Programs are indexed to inflation, the asset levels are not, and have been static over several years. Consequently, many persons who meet the Medicare Savings Programs income threshold could not qualify for assistance because they had excess resources. This is especially true in Connecticut, where persons with higher incomes qualify for the Medicare Savings Programs because of the increased income disregards.

- **Because the federal government fully funds the QI benefit, states may be more willing to expand enrollment in this program by eliminating the asset tests.** Given the cost-neutral effect of removing the QI asset test, Connecticut approved the change effective April 2001. In contrast, the state did not believe it could afford to abolish the resource limits for the QMB and SLMB programs, which require the state to match federal money at the customary Medicaid rate.

- **Estate recovery can be a barrier to Medicare Savings Programs participation**. Connecticut's Medicaid estate recovery program includes expenditures for persons whose Medicaid assistance was limited to the Medicare Savings Programs. State officials and advocates believed that eligible persons choose to forgo benefits based on the desire to

preserve a legacy for their children or the incorrect belief that enrolling in the Medicare Savings Programs would allow the state to seize their homes.

- **Federal law permitting states to forgo paying Medicare co-insurance to providers who serve QMBs may be eroding the value of the QMB benefit.** In Connecticut, many providers have traditionally participated in Medicare but not in Medicaid, as Medicare payments were more competitive with private insurance payers while Medicaid payments tended to be much lower. Following a 1997 change in federal law, Connecticut has adopted a policy that effectively enables the state to withhold Medicare co-insurance to providers serving QMBs, effectively forcing them to take a 20 percent cut. The state and SHIPs suspect that some providers are declining to serve QMBs because of the reduced reimbursements.

- **Separate, shortened applications forms can help facilitate Medicare Savings Programs enrollment but may present barriers to receipt of other benefits for which individuals may qualify.** In 1999, Connecticut implemented a short Medicare Savings Programs application form that eliminated income and asset verifications and did not require an in-person interview. The State Unit on Aging, SHIP, and other community partners uniformly lauded the forms as an improvement over the 14-page Medicaid application. However, state Medicaid officials noted that applicants who submit the short form are not screened for full Medicaid unless they also submit the general, full application form.

- **States can allow applicants to self-declare their income and assets without undermining program integrity.** Because documentation requirements were perceived as an obstacle to Medicare Savings Programs participation, Connecticut waived income and asset verifications for the shortened Medicare Savings Programs application. The state believes that automated collateral verification systems can detect most inaccuracies and has not observed an increase in errors or fraud since the change was made.

- **State efforts to update and maintain their enrollment infrastructure play a significant role in facilitating the receipt of assistance by eligible state residents.** For example, the Connecticut Department of Human Services engages in comprehensive, ongoing training and education activities for its local public assistance staff given their critical role in enrolling persons for benefits. Additionally, the state has updated its computer system to prevent delays in benefits and inappropriate terminations. State officials report that these steps have been important in Connecticut's Medicare Savings Programs efforts.

- **While much attention has been focused on streamlining application procedures, there has been less effort to address issues in eligibility renewal to promote Medicare Savings Programs participation**. In Connecticut, the state Medicaid agency initially concentrated on simplifying the application and enrollment process, but overlooked the necessity to streamline the renewal process. The state later instituted the short application form for use upon yearly renewal. Given the lack of evidence that the renewal process undermined Medicare Savings Programs enrollment retention, the state was not inclined to adopt the use of pre-printed forms and passive renewals in which enrollees need only indicate changes in information.

- **Sustained commitment by the state is necessary to achieve Medicare Savings Programs enrollment gains.** Connecticut actively embraced the goal of increasing Medicare Savings Programs enrollment and did not lose focus even when some of its efforts were unsuccessful. Connecticut went on to achieve a nine percent enrollment increase from September 2000 to September 2001 by refining its outreach interventions and removing the QI asset test.

- **Active involvement by the federal government and local advocates also play a significant role in promoting greater use of the Medicare Savings Programs.** CMS monitoring and technical assistance initiatives—as well as outreach funding—encouraged and facilitated Connecticut's enrollment simplification and outreach efforts. Similarly, demands for improvements from legal services attorneys helped to propel the state's initiative to increase Medicare Savings Programs enrollment. Finally, assistance by the Center for Medicare Advocacy, Inc. and the SHIPs promoted Medicare Savings Programs enrollment by helping to train services professionals about the programs and by providing information and application assistance to Medicare beneficiaries.

- **Collaborating with community partners enables the Medicaid agency to better market the Medicare Savings Programs to low income Medicare beneficiaries.** To distance the Medicare Savings Programs from negative welfare connotations and obtain a "passport" to the community, the Connecticut Department of Social Services partnered with established local agencies and organizations that serve Medicare consumers. In addition to traditional partners, such as SHIPs and Area Agencies on Aging, the state began to rely on community health centers to reach out to eligible persons. Although health centers have traditionally focused on promoting Medicaid participation for children and families, the centers present a promising venue for Medicare Savings Programs outreach because they come into contact with Medicare Savings Programs eligibles and have a financial incentive to build their Medicare patient population. Further, the state has begun efforts to education service providers about the Medicare Savings Programs, as these professionals have ongoing contact with beneficiaries and have often earned their trust.

- **Outreach campaigns and streamlined enrollment procedures alone may not significantly increase Medicare Savings Programs enrollment**; **expanded eligibility criterion may also be needed.** To increase Medicare Savings Programs participation rates, Connecticut undertook numerous efforts toward community outreach, simplification of the application process, and organizational partnerships. Despite these efforts, participation rates remained relatively constant, indicating that an administrative change was necessary. Once the state abolished the QI asset test, the state's continued outreach and enrollment efforts produced appreciable enrollment increases.

- **Direct mailings can be a useful tool to generate applications, but work only when they are well-designed and sent to the appropriate audience**. After waiving the QI asset test, Connecticut conducted several direct mail campaigns, which resulted in differing success rates. A direct mailing to state pharmacy assistance enrollees generated a 16 percent response, while an immediately subsequent mailing to low-income households based on commercial mailing lists generated a one percent return rate. State officials concluded that

direct mailings can be successful if the targeted audience is receptive to benefit programs, if the benefit package fits the targeted audience, and if the mailings are staggered in order to avoid market saturation.

- **Outreach to under-served populations is especially challenging and will likely require repeated attempts and contacts in the community to achieve results.** In order to reach under-served populations such as homebound persons living alone and Hispanic and African-American eligible persons, the Medicaid agency and a local Area Agency on Aging sought to develop long-term relationships with churches and gain entry to conduct Medicare Savings Programs presentations and provide application assistance. After a mailing to local churches and follow-up phone calls, most churches declined involvement. The state considered the endeavor the first step to initiating ties with the church community and resolved to continue efforts in this regard.

Appendix A: Simplified, Mail-in Medicare Savings Programs Application

State of Connecticut
Department of Social Services
Medicare Buy-in Application
December 1999

W-1429
(New 12/99)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

EBAR

MEDICARE BUY-IN APPLICATION
(QMB, SLMB, ALMB, QDWI)

NAME AND ADDRESS

Name *(first)* *(m.i.)* *(last)*

Address *(no.)* *(street)* *(city)* *(zip code)*

Mailing Address *(if different)* *(no.)* *(street)* *(city)* *(zip code)*

Telephone
Your # ( ) _____
Message # ( ) _____

Marital Status
☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Applying For *(check one)*
☐ Self Only ☐ Self and Spouse

Name of Spouse *(first)* *(m.i.)* *(last)*

	Date of Birth	Place of Birth	Race	Social Security Number	Sex *(circle one)*	Maiden Name	Do You Have Medicare? Part A *(circle one)*	Part B *(circle one)*
Self					M F		Y N	Y N
Spouse					M F		Y N	Y N

INCOME

Please list gross income received by you and your spouse. Income includes gross Social Security (including your Medicare Part B premium), SSI, wages, pensions, disability benefits, Worker's Compensation, unemployment compensation, interest, dividends, rental property income, alimony, child support, etc.

SELF			SPOUSE		
Name and Address of Employer, if any:			Name and Address of Employer, if any:		
Name of Pension Company:			Name of Pension Company:		
Source	**How Often Received (Weekly, Monthly or Quarterly)**	**Amount**	**Source**	**How Often Received (Weekly, Monthly or Quarterly)**	**Amount**
Social Security		$	Social Security		$
SSI		$	SSI		$
Wages *(enter gross)*		$	Wages *(enter gross)*		$
Pension		$	Pension		$
Annuity		$	Annuity		$
Other *(describe)*:		$	Other *(describe)*:		$
Other *(describe)*:		$	Other *(describe)*:		$

ASSETS

List all assets owned by you and/or your spouse. Include cash on hand *(money that is not in an account)*, savings and checking accounts, certificates of deposit (C.D.), individual retirement accounts (I.R.A.), vacation and Christmas clubs, revocable and irrevocable burial funds/accounts or any other type of account where your name appears on the account *(even if the money is not yours*). Include accounts such as those for children or those held in trust for you. List other types of assets such as contents of a safe deposit box, mortgage payable to you, jewelry, furs, and/or paintings held for investment, etc. Under VEHICLES, list any car, truck, boat, camper, recreational vehicle, trailer, motorcycle or other vehicle *(include unregistered vehicles)* that you own or have registered in your name. Under INSURANCE POLICY OR DEATH BENEFIT please be sure to enter the face value (the amount that appears on your policy) and if it is a whole life policy, the cash surrender value.

Asset Type	Owner (self or spouse)	Name of Bank, Fund, etc.	Description	Account or Policy No.	Value
Cash on Hand					$
Bank/Credit Union					$
Bank/Credit Union					$
Annuity					$
Trust					$
Revocable Burial Fund					$
Irrevocable Burial Fund					$
Stocks					$
Bonds					$
Other:					$
Other:					$
Other:					$

VEHICLES

Owner	Make	Model	Year	Value	Amount Owed on Loan
				$	$
				$	$
				$	$

INSURANCE POLICY OR DEATH BENEFIT

First name of Policy Owner	Insurance Co.	Policy No.	Type *(check one)*	Face Value	Cash Value
			☐ Term ☐ Whole Life	$	$
			☐ Term ☐ Whole Life	$	$
			☐ Term ☐ Whole Life	$	$

REAL ESTATE

Address of Property Owned	Owner (self, spouse or joint)	Estimated Value	Amount Owed on Mortgage	Do you live in this property?
		$	$	☐ Yes ☐ No
		$	$	☐ Yes ☐ No
		$	$	☐ Yes ☐ No

INHERITANCE

Do you have an inheritance pending? ☐ Yes ☐ No If Yes, provide details:

PENDING LAW SUIT

Are you suing anyone? ☐ Yes ☐ No If Yes, provide details, including the name of your attorney:

CITIZENSHIP

	U.S. Citizen? *(circle one)*	If no, enter alien status, e.g., permanent resident, refugee, etc.	Alien Registration Number	Country of Origin	Place and Date of Entry into U.S.	Name of Sponsor *(if applicable)*
SELF	Y N					
SPOUSE	Y N					

READ CAREFULLY AND SIGN

I certify that all of the statements made in this application are true and complete to the best of my knowledge. If I have knowingly given incorrect information, I may be subject to the penalties for false statements as specified in Connecticut General Statute Sections 53a-157b and 17b-97 and to penalties for larceny as specified in sections 53a-122 and 53a-123.
I may also be subject to penalties for perjury under Federal law.

I understand and agree to the following:

- This application constitutes a request for Medicare Buy-In programs only (QMB, SLMB, ALMB and/or QDWI).
- If I wish to apply for the Department's other programs, such as cash assistance, Medicaid or Food Stamps, I must complete a separate application form.
- My Social Security number will be used to verify identity and eligibility. My Social Security number may also be used to cross-match information in federal, state and local government files.
- The information on this form is subject to verification by federal, state and local officials. The Department may conduct independent verification of the statements made by me on this application.
- The information available to the Department through the Income and Eligibility Verification System (IEVS) will be requested and used to process my request for assistance. This information will come from the Department of Labor, the Social Security Administration and the Internal Revenue Service as well as other agencies when allowed by law. Information received may also be verified directly with other sources such as banks and employers. Results from such investigations may affect my eligibility and level of benefits.
- I agree to cooperate with state and federal personnel in a Quality Control Review.
- I must notify the Department within 10 days of any changes in my income or assets.
- The information given on this form is confidential and will only be used for purposes of program administration.
- I may request a fair hearing in writing if I disagree with an action taken on my case.
- I swear that I am a United States Citizen or, if I am not, that the information I have provided concerning my non-citizen status is true.
- I understand that false or misleading statements on this application violate federal law and may be punishable by a fine up to $25,000 or imprisonment for 5 years, or both.
- I agree to an assignment of pending lawsuit money to the State for medical expenses related to the lawsuit and paid by QMB.
- I understand that by receiving medical assistance, I allow the State to recover the cost of my medical bills which may have been covered by other insurance directly from the insuring company.
- I understand that the State may recover monies from the estates of individuals who received medical assistance benefits and who do not have a living spouse or a surviving child who is under age 21 or blind or disabled.
- I give permission to any health insurer or provider to release information about me to the Department of Social Services. The information requested must concern my claim for medical benefits from the state.
- I will not alter, trade, sell, or use someone else's medical services identification card.
- I understand that my spouse, if I am separated from him or her, may be billed to repay the State for the cost of my medical care.

Applicant's Signature Date

Spouse's Signature Date

Conservator or other Representative's Signature, if applicable Date

This application will be considered without regard to race, color, sex, age, physical or mental disability, religious creed, national origin, sexual orientation, ancestry, language barriers or political beliefs.

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR TDD/TTY (800) 842-4524.

Appendix B: Outreach Letter to State Pharmacy Assistance Program Recipients and Low-in Households

State of Connecticut
AARP, the Area Agencies on Aging, and the Connecticut Department of Social Services
Spring 2001

NORTH CENTRAL AREA AGENCY ON AGING

Medicare is expensive! Medicare Savings Programs can help beneficiaries save $600 per year or more! The Medicare Savings programs provide financial assistance to seniors and other eligible individuals by paying the coinsurance and deductibles not paid by Medicare. Unfortunately, many people are not aware of these programs and their benefits.

Research has confirmed again and again that churches and religious organizations are pivotal influences in the lives of many seniors and are considered a trusted source of information. The CHOICES program at the North Central Area Agency has designed an outreach project that enlists the help of churches and other faith-based organizations in an effort to spread the word about these under-utilized and least understood programs. We hope that you can help us! Affordable health care is one of the primary concerns of seniors and disabled individuals on Medicare. These programs speak directly to this concern.

We have enclosed for your review a brochure outlining the benefits and other useful information. This also provides you with the programs' eligibility standards.

We would welcome the opportunity to speak with you to further discuss the intent of our outreach project or to meet with you personally to discuss in more details the benefits of these programs.

Please call CHOICES at (860) 724-6443 for more information. We would be happy to provide you with more detailed information in the form of a presentation upon request. Feel free to contact us to confirm your receipt of this letter. We would be happy to assist you and answer any questions you may have.

Thank you in advance for your consideration.

Sincerely,

Maureen C. McIntyre
CHOICES Regional Coordinator

Orlando O. Wright
Intern/Medicare Savings Program Outreach Grant

TWO HARTFORD SQUARE WEST · SUITE 101 · HARTFORD, CT 06106-5129
Telephone 860/724-6443 / 1-800/994-9422 · FAX 860/251-6107

Bulletin

Medicare Savings Plan

QMB: Qualified Medicare Beneficiary
SLMB: Specified Low-Income Medicare Beneficiary

Generally, if your monthly income * is at or below these levels...	You may qualify for...
$ 879 single $1304 couple	QMB - This program is equivalent to a "Medigap" policy. It pays your Part B premium[1] and your Medicare deductibles[2] and co-insurance[3] up to the approved Medicaid rate. [1] Part B = $45.50/month in 2000. (This amount increases every year.) [2] The 2000 hospital deductible is $776 (This amount increases every year.) [3] Co-insurance is the portion of Medicare approved services that you are responsible to pay. This is usually 20% of the approved Medicare charge.
$ 1018 single $1491 couple	SLMB - This program pays for your Part B premium only ($45.50/month).
$ 1123 single $1632 couple	ALMB (group 1)* - This program for your Part B premium only ($45.50/mo.), subject to available program funding.
$ 1401 single $ 2007 couple	ALMB (group 2)* - This program only pays for a small portion of your Part B premium ($2.87 per month in 2000); however, this amount increases every year. * This program is subject to available funding.

- These income limits became effective on April 1, 2000. They generally increase on April 1 of every year.

Contact: North Central Area Agency on Aging 860-724-6443

Maureen C. McIntyre
CHOICES Regional Coordinator

Orlando O. Wright
Medicare Savings Program outreach

AARP

Dear Friend:

AARP, the Area Agencies on Aging, and the Connecticut Department of Social Services (DSS) are trying to spread the word about a federal program called the Medicare Savings Program that helps pay for some people's Medicare coverage. We think there are many older people in Connecticut who don't know about the program.

If you, or an older friend or relative, are receiving Medicare, you probably know that it doesn't mean free medical care! There are costs that come out of your pocket. But the Medicare Savings Program will pay many of the out-of-pocket expenses for you, if your income indicates you should apply. The extra money you save can then be used for other daily living expenses – maybe a new coat, your prescription drugs, that bill you couldn't quite pay last month, or a gift for your grandchild.

People who qualify for the Medicare Savings Program have their monthly Medicare Part B premium, or a portion of that premium, paid for by the government. In 2001, the premium will be $50 a month – which means you could be saving $600 a year. In some cases, this program also will pay your hospital deductibles and coinsurance, meaning *additional* savings whenever you need medical care.

For an individual, if your monthly income is not more than $1,042.20, or $1,527.60 for a couple, and you have personal savings of less than $4,000 for an individual, or $6,000 for a couple, **you may be eligible to have all of your Medicare premium paid for.**

If you are single, and your income is not more than $1,436.00, or $2,060.00 for a couple, **you may be eligible to have all, or part, of your Medicare premium paid for.** Effective April 1, 2001, there is no limit on the amount of your personal savings for people in this income range.

To find out if you, or a friend or relative can receive this assistance, **fill out the enclosed application and mail it to the Connecticut Department of Social Services (no postage required).** If you prefer, you may call your local Area Agency on Aging at 1-800-994-9422 and a trained health insurance counselor will answer your questions and provide assistance. Also call this number if you need a Brochure and Application that is printed in an alternate format such as Spanish. Remember, there is no cost for this service. **Any information you share with this counselor will be kept strictly confidential.**

Thanks for taking the time to read this. We care about you and the quality of your life. The Medicare Savings program could help you have extra money every month. It's your right! We hope to hear from you.

Sincerely,

Horace B. Deets

601 E Street, NW Washington, DC 20049 (202) 434-2277 www.aarp.org
Esther "Tess" Canja, President
Horace B. Deets, Executive Director

Appendix C: Medicare Savings Programs Brochure

State of Connecticut
Department of Social Services and the Area Agencies on Aging
Spring 2001

1. How can I receive an extra $50 each month?

If you have Medicare, you pay a $50 premium each month for your Part B Medicare coverage. (Part B pays for doctor bills, lab tests, x-rays, etc.)

You may not realize you are paying this premium because it is automatically deducted from your Social Security check each month.

If you qualify for three of the four Medicare Savings Programs described in this brochure, the State of Connecticut will pay the Part B premium for you. **Your Social Security check will then increase by $50 each month!**

2. Are there other benefits?

Yes! If you qualify for QMB, we will pay your Medicare coinsurance (co-payments) and deductibles, up to the Medicaid rate. In some cases, we may also pay your Medicare Part A premium. (See question 11.) These benefits could save you hundreds or even thousands of dollars each year!

To qualify, you must be eligible for Medicare Part A. In addition, your income and assets must be within program limits. Please see the table on the back for a description of benefits at each income level.

3. Is there a cost to me?

No! There is no charge to you for any of the benefits under these programs.

4. What is the asset limit?

For QMB and SLMB, countable assets may not be more than $4,000 for one person or $6,000 for a married couple. However, effective April 1, 2001, there is no asset limit for the ALMB programs!

5. What are assets?

Assets include bank accounts, stocks, bonds, annuities, trusts, non-home property, some types of life insurance policies, etc. However, not all assets are counted in determining your eligibility. Some assets, such as term life insurance policies and irrevocable burial funds, are totally excluded.

6. What if I own a home or a car?

The home you live in, one automobile, home furnishings, personal effects and burial plots are not counted toward the asset limit. We do <u>not</u> place a lien on the home you live in, but we do recover benefits paid on your behalf from your estate.

7. Is there an income limit?

Yes. The level of help that you receive depends on your countable income. The table on the back shows the benefits available at different income levels.

8. What is income?

Income includes Social Security, pensions, disability benefits, wages, alimony, rental income, interest and dividends. However, not all income is counted.

We allow certain deductions in calculating your countable income amount. For example, we do not count the first $183 of unearned income (such as Social Security or pension). That is a $366 exemption for a married couple. We also disregard a portion of any earned income you may have from employment.

9. How do I apply?

Contact the Department of Social Services office nearest you. Or telephone a CHOICES health insurance counselor at your Area Agency on Aging. They will answer your questions send you our simple four-page application and a postage paid return envelope.

To reach a CHOICES counselor, call

1-800-994-9422

10. Will I need to provide any documents?

You do not need to provide any documents other than your completed application. The Department will independently verify the information you provide on the application form.

We will also verify that you either have or are eligible for Medicare Part A coverage. (Part A pays for hospital care and other inpatient services.) In most cases, the premium for Part A is paid for by the federal government, not by the Medicare beneficiary.

11. What if I don't have Part A?

Some people choose not to take Part A when they become eligible for Medicare. They can change their minds later, but in this case, the Medicare beneficiary pays the Part A premium rather than the federal government.

If you were eligible for Part A but elected not to take it at enrollment, the State of Connecticut will pay the Part A premium for you under the QMB program.

If you are not sure whether you have Part A, check your Medicare card or call the Social Security Administration at 1-800-772-1213.

Generally, if your monthly income Is at or below these levels...	You may qualify for...
$ 899.00 single $ 1,334.00 couple	QMB - This program is similar to a "Medigap" policy. It pays your Part B premium(1) and all Medicare deductibles(2) and co-insurance.(3) (1) Part B = $50 in 2001. (This amount increases every year.) (2) The 2001 hospital deductible is $792 (This amount increases every year.) (3) Co-insurance is the portion of Medicare approved services that you are responsible to pay. This is usually 20% of the approved Medicare charge, up to the Medicaid approved rate.
$ 1,042.20 single $ 1,527.60 couple	SLMB - This program pays for your Part B premium only ($50/month).
$ 1,149.60 single $ 1,672.80 couple	ALMB (group 1)* - This program for your Part B premium only ($50/mo.), subject to available program funding.
$ 1,436.00 single $ 2,060.00 couple	ALMB (group 2)* - This program only pays for a small portion of your Part B premium ($3.09 per month in 2001); however, this amount increases every year. * This program is subject to available funding.

These income limits became effective on April 1, 2001.
They generally increase on April 1 of every year.

COULD YOU USE UP TO $50 * EXTRA EVERY MONTH?

****

If you already have this program, or if you have an application pending, pass this mailing along to a friend!!!

****

If you are eligible for Medicare Part A, you may qualify for one of the State of Connecticut's

MEDICARE SAVINGS PROGRAMS

These programs (QMB, SLMB and ALMB) help to pay for your Medicare premiums and, in some cases, for your Medicare coinsurance and deductibles.

Look inside to see if you qualify...

Deaf and hearing-impaired persons may use a TDD/TTY by calling 1-800-842-4624. Questions, concerns, complaints or requests for information in an alternative format may be directed to 1-860-424-5250.

This is the amount of Medicare's Part B monthly premium starting January 1, 2001.

The Henry J. Kaiser Family Foundation is an independent, national health care philanthropy dedicated to providing information and analysis on health issues to policymakers, the media, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

1330 G Street NW, Washington, DC 20005
Phone: 202-347-5270, *Fax:* 202-347-5274
Website: www.kff.org

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