State Solutions
An Initiative to Improve Enrollment in Medicare Savings Programs

Maximizing Medicare Savings Program Enrollment through Medicare Part D

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May 2005

Introduction

The passage of the Medicare Prescription Drug, Modernization and Improvement Act of 2003 (MMA) presents a number of opportunities to increase enrollment in the Medicare Savings Programs (MSPs),[a] which have historically been chronically underenrolled. In particular, the generous Part D low-income subsidies (LIS) available in 2006 offer an attractive new benefit to the same Medicare beneficiaries that are eligible for Medicare Savings Programs. To the degree that Part D outreach, education, and enrollment efforts can be coordinated or integrated with MSP enrollment efforts, low-income Medicare beneficiaries could see immediate relief, in their out-of-pocket spending for both purchasing prescription drugs and paying higher Part B premiums.

This issue brief describes the new Part D benefit and related changes to the Medicare program that represent potential opportunities for expanding MSP enrollment. In particular, we highlight some of the opportunities to forge new alliances between different stakeholders with shared interests. We also discuss some potential obstacles and concerns raised by the Part D regulations and the implications for MSPs.

This policy brief is one in a series to be released by the State Solutions National Program Office to identify mechanisms for improving enrollment in MSPs. The findings in this brief are based on 1) a review of the MMA statute, regulations and related literature; as well as 2) interviews with state officials in Medicaid and state pharmacy assistance programs (SPAPs), CMS officials, and representatives of private card sponsors, managed care organizations and enrollment brokers that were conducted in the Spring/Summer of 2004. It is a background paper for a special invitational summit that the State Solutions National Program Office is hosting in May 2005, which will bring together representatives from multiple agencies and potential partnering organizations to formulate a joint plan of action and operational strategy for maximizing MSP enrollment through the Medicare Part D benefit.

[a] Medicare Savings Programs include the Qualified Medicare Beneficiary (QMB) created under the Medicare Catastrophic Coverage Act of 1988, the Specified Low-Income Medicare Beneficiary (SLMB), and the Qualified Individual (QI-1) program defined under the Omnibus Budget and Reconciliation Act for 1990 and the Balanced Budget Act of 1997 (respectively).

State Solutions

A national program of The Robert Wood Johnson Foundation® and The Commonwealth Fund.

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Part D Benefits and Low-Income Subsidies

Effective January 2006, the basic Medicare Part D benefit will be available to anyone who is entitled to Medicare Part A or enrolled in Medicare Part B. Like Part B, the new Part D benefit is voluntary and has an additional premium for those who choose to enroll. Beneficiaries already enrolled in a Medicare Advantage (MA) plan that offers qualified drug coverage must obtain coverage through that plan. Beneficiaries in the traditional Medicare fee-for-service program or in a MA plan without qualified drug coverage can sign up for either a freestanding privately-administered prescription drug plan (PDP) or a qualified Medicare Advantage prescription drug plan (MA-PD). The standard prescription drug benefit includes covered Part D drugs[b] within the approved PDPs' or MA-PDs' formulary; subject to an annual deductible, 25 percent coinsurance up to an initial coverage limit and catastrophic coverage after an individual incurs out-of-pocket expenses above a certain threshold. The gap in coverage between the initial coverage limit of $2,250 and the catastrophic limit of $5,100 has been commonly referred to as the "doughnut hole," during which time the individual is responsible for 100 percent of their drug costs.

Low-income Medicare beneficiaries, including those who are eligible and/or enrolled in the MSPs, are also eligible for additional low-income subsidies (LIS) beyond the basic Part D benefit that are quite generous. As shown in Table 1, there are different subsidies available to those who are institutionalized or non-institutionalized full dual eligibles (i.e., fully covered for Medicare and Medicaid covered services), and those who earn less than 135 percent of federal poverty level (FPL) or between 135 and 150 percent of FPL who meet certain asset requirements. While income eligibility for the full subsidies are comparable to the MSP programs,[c] the LIS asset tests are higher than the federal standard for the MSPs, which are twice the Supplemental Security Income (SSI) level at $4,000 and $6,000. Note that several states use more liberal asset standards for the MSPs than the federal standard and in these cases, the asset test for the MSPs is actually higher than for the LIS. In general, full subsidy eligible persons will receive prescription drug coverage for all Part D drugs within the plan's formulary with no premiums or deductibles, no gaps in coverage, as will be the case for higher income Medicare beneficiaries for drug costs in the "doughnut hole," and nominal copayments.

[b] Part D covered drugs include all prescription drugs, biological products, insulin and medical supplies for insulin injection, and vaccines approved by the FDA to be used for a medically accepted indication except those that are excluded or restricted from coverage under Medicaid. Part D will not cover drugs available under Part A or B, even if the individual is not enrolled in these programs. This further supports the idea that low-income Medicare beneficiaries be screened for eligibility for the MSP Part B buy-in programs at the same time as Part D to ensure access to all Medicare-covered drugs.

[c] There may be some differences in income disregards allowed under Part D and income disregards in individual states' MSP programs.

Table 1. Medicare Part D and Low-Income Subsidies

Eligibility		Benefit			
Income	Assets	Premium	Deductible	Cost Sharing	Cost-Sharing above Out-of-Pocket Limit
Institutionalized and Medicaid Eligible *	Medicaid asset test	None	None	None	None
Eligible for Medicaid *	Medicaid asset test	None	None	$1 Generic $3 Brand name	None
Below 100% FPL *	$6,000 single $9,000 couple	None	None	$1 Generic $3 Brand name	None
Below 135% FPL **	$6,000 single $9,000 couple	None	None	$2 Generic $5 Brand name	None
Below 150% of FPL	$10,000 single $20,000 couple	Sliding scale	$50	15% coinsurance	$2 Generic $5 Brand name
150% FPL or Above	Below 150% FPL but assets above $10,000 single $20,000 couple	$35/month	$250/year	25% up to initial coverage limit of $2500, 100% during donut hole	Greater of 5% or $2 Generic/ $5 Brand name

* In 2006, Medicare will assume responsibility for prescription drug coverage for Medicare beneficiaries who have been receiving their drug coverage under Medicaid, referred to as the dual eligibles. Dual eligibles will be automatically eligible for low-income subsidies and automatically enrolled into a PDP with premiums at or below the low-income benchmark if no plan is selected by 11/05.
** Persons enrolled in the Medicare Savings Programs (i.e. QMBs, SLMBs, and QI-1s) are automatically eligible for low-income subsidies; all others must apply to SSA or Medicaid. All persons including MSP enrollees must enroll separately into a PDP/MA-PD of their choice by Spring 2006. Guidance issued on April 5, 2005 indicates that CMS will facilitate enrollment for LIS eligible individuals that do not enroll voluntarily. Source: CMS. Auto-Enrollment and Facilitated Enrollment of Low-Income Populations. April 5, 2005.

Source: CMS. Federal Register 42 CFR Parts 400, 403, 411, 417, and 423: Medicare Program; Medicare Prescription Drug Benefit; Final Rule. Department of Health and Human Services. January 28, 2005, pp. 4388-89.

Enrollment in PDPs and Applying for Low-Income Subsidies

The initial enrollment period into Part D PDP and MA-PD plans will run from November 15, 2005 until May 15, 2006. Subsequent annual election periods during which beneficiaries can elect to change plans will run from November 15th until December 31st. Once someone has enrolled in a Part D plan, they cannot disenroll and reenroll into another Part D plan until the next enrollment period, unless they are eligible for a special election period (SEP).

Eligibility determination for the Part D low-income subsidies may be made by either the SSA or the state Medicaid agency. Both entities are required to begin accepting low-income subsidy applications on July 1, 2005. The details of how these eligibility responsibilities will be divided up and the degree to which states will be required to educate or participate in outreach to these low-income Medicare beneficiaries is still being determined. CMS and SSA are currently in the process of developing a model application process and draft SSA regulations have been published for public comment.[1]

Enrolling in a PDP or MA-PD provides the individual with coverage comparable to the standard Part D benefit; it does not automatically provide low-income persons with the additional subsidies for which they may be eligible. Only individuals who are already enrolled in Medicare Savings Programs or are full dual-eligibles are automatically eligible for the low-income subsidies, giving MSP enrollees a distinct advantage over those who are not enrolled in MSPs or who are not full dual-eligibles. All other low-income beneficiaries must apply for and be determined eligible for the subsidies in addition to applying for the PDP or MA-PD in which they wish to enroll. QMB, SLMB, and QI-1s are deemed automatically eligible for full subsidy assistance, because by definition nearly all would meet the Part D eligibility requirements except in the few states that have more liberalized asset rules. As concluded by the Secretary in the final Part D regulations, deeming MSP enrollees automatically eligible would not have a large cost impact and would ease the administrative burden of educating these individuals on the need to apply for the subsidy.[2]

Although MSP enrollees do not need to apply for the low-income subsidies, they will still need to voluntarily enroll in a PDP. The final regulations allow CMS to "facilitate enrollment" for MSPs, similar to how dual eligible enrollees who do not select a PDP by a certain date would be randomly assigned into a PDP in their region. CMS recognizes the value of getting MSP enrollees enrolled in Part D plans both for health reasons and to avoid late penalty fees being imposed and have released further guidance outlining their process for facilitating MSP enrollment in Part D plans if they do not voluntarily enroll by April or May 2006. CMS' proposed facilitated enrollment process for MSPs is similar to the process for the duals, except that MSP facilitated enrollment will not occur until May 2006,[d] and MSP individuals who are autoenrolled and subsequently wish to change plans will only be allowed one special election period, while the duals have unlimited special election periods.[3] The details on the facilitated enrollment process are still under discussion representing an opportunity for interested stakeholders to provide input on improving the process.

Options for Increasing MSP Enrollment through Part D

The implementation of the new Part D benefit will involve many different entities. As shown in Chart 1, the MSP target low-income Medicare population is likely to have contact with and/or receive information related to the Part D benefit from five or six different types of agencies or private entities and potentially

[d] The autoenrollment of duals will occur in November and December 2005 to ensure that all duals are enrolled in the Medicare benefit before their Medicaid drug coverage ends effective January 1, 2006.

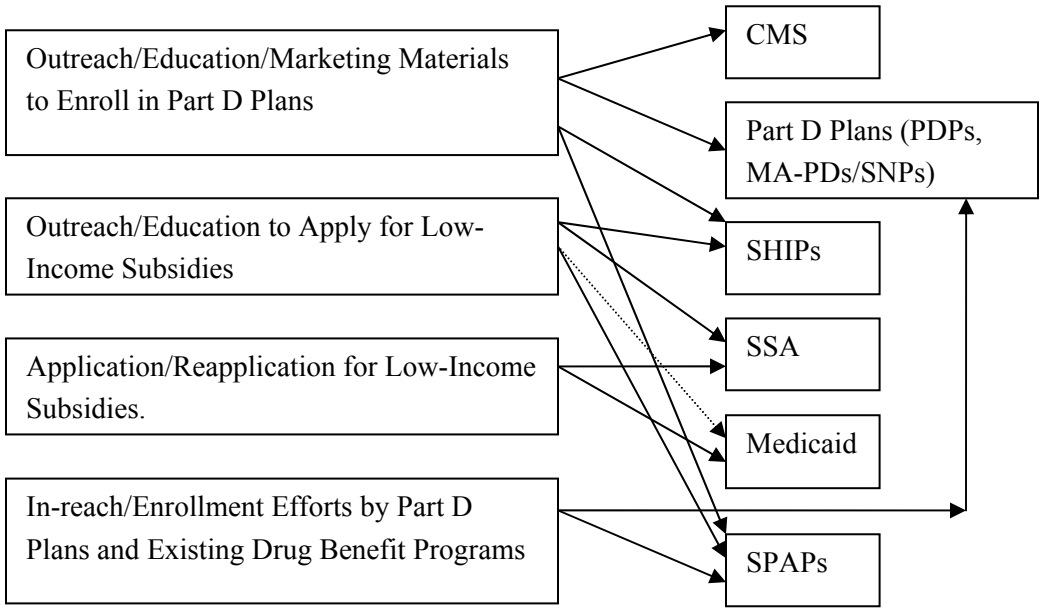
many more. Any of these entry points could represent an opportunity to inform low-income enrollees that they may also be eligible for premium and cost-sharing assistance for Medicare Part B and get them enrolled.

The following are several ways in which to expand MSP enrollment through the Part D outreach, eligibility, and enrollment process:

- Utilizing the extensive Part D outreach, education and marketing efforts to publicize the availability of Medicare Savings Program to buy-in to Part B;
- Expanding the screening requirement for MSPs when applying for Part D low-income subsidies and modifying the states' MSP eligibility to match or exceed those required for the Medicare Part D benefit;
- Working with state pharmacy assistance programs for low-income Medicare beneficiaries to identify and enroll MSP eligible persons within their current enrollees; and
- Conducting in-reach to Part D enrollees once they enroll in PDPs and MA-PDs and Special Needs Plans to identify MSP eligible persons within their membership.

Each of these strategies may require partnership with other entities that may or may not have the shared interest of maximizing enrollment in MSPs, but may have complementary interests that would support collaboration. We discuss these common interests, the feasibility and the pros and cons of each option, the increased enrollment potential, and related experience during the Medicare discount card program that may provide some lessons as to the likelihood of success.

Chart 1. Points of Contact for Part D Benefit and Low-Income Subsidies with Potential MSP Eligibles



Incorporating MSP Information in Part D and LIS Outreach and Education

Outreach and education about the Part D benefit in general and the low-income subsidies in particular will be shared across CMS, SSA, SHIPs and state Medicaid and state pharmacy assistance programs (SPAPs) and may begin as early as Spring 2005, since eligibility determination for low-income subsidies is targeted to begin in July. The MMA authorizes up to $200 million annually starting in fiscal year 2006 to be spent on beneficiary education and enrollment activities supported in part by user fees from the PDPs and MA plans. CMS plans to use information dissemination activities similar to and coordinated with dissemination activities for Medicare Advantage with a special emphasis on ensuring that low-income individuals eligible for or currently enrolled in Part D benefits are aware of additional subsidies available to them. The regulations indicate that "this public information campaign would include outreach, information, mailings, and enrollment assistance through appropriate state and federal agencies - including State health insurance assistance programs (SHIPs) - and would coordinate with other Federal programs providing assistance to low-income individuals."[4]

SSA regulations defining their eligibility determination process were released on March 4, 2005. Those regulations do not address SSA's outreach efforts to inform persons of their potential LIS eligibility or how they plan to coordinate LIS outreach with the letters that SSA has sent in the past to notify persons of potential eligibility for the MSP programs, which have been demonstrated to be successful in getting persons enrolled in the MSPs.[5] Since these populations overlap considerably there is a clear opportunity to promote both programs. In addition, access to prescription drugs and access to physician services are interdependent. To take advantage of pharmacy coverage, people need to have access to physicians who prescribe medications, which is available through the Part B buy-in program. So this would seem to be an ideal opportunity to promote both programs.

Unfortunately, many of these opportunities were missed during the Medicare discount card program. For the discount card program, CMS' outreach materials included a letter that was sent to all Medicare beneficiaries to inform them of the new discount card program in early Spring 2004. CMS also produced a discount card guide that was available to all Medicare beneficiaries who called 1-800-MEDICARE and requested it. In addition, SSA sent out a second letter targeted to low-income Medicare beneficiaries to inform them of the transitional assistance available through the discount card program. None of these communications mentioned the additional assistance available to Medicare beneficiaries who qualify to buy-in to Medicare Part B through the MSPs.

According to CMS and SSA officials, marketing research and focus groups that they had conducted indicated that, to be most effective, education materials should focus on only one benefit. One could argue that in this case the availability of one benefit is directly tied to taking advantage of the second benefit (i.e., that one needs to visit a doctor in order to get a prescription for a Part D drug) and since the Part D benefit does not cover Part B covered drugs, there may be reasonable grounds to develop a joint message that could promote both programs for low-income Medicare beneficiaries. At a minimum, to pursue this approach, it is clear from the discount card experience that timing is important and that, in

order to incorporate messages to publicize the availability of MSP programs in outreach and education materials, states and advocates must start working with CMS and SSA as early as possible.

To the degree that Medicaid agencies will also be responsible for outreach and education of the Part D LIS benefit as one of the entities designated to do eligibility determinations, this may be another source that could include reference to the MSPs. State Medicaid agencies are responsible for educating Medicaid full dual eligibles about the transition to the new Medicare benefit when the Medicaid drug benefit expires in January 2006, but are unlikely to be involved in any other outreach or education efforts. Based on the discount card experience and current budgetary situations, the state Medicaid agencies are likely to do the minimum required to promote the program. With a few exceptions, most of the state Medicaid agencies we contacted had no plans to get their MSP enrollees enrolled into a Medicare discount card to access the $600 credit. Given limited resources available for outreach, most states relied on CMS and private drug card companies to inform MSP enrollees of the discount card and to get them enrolled into transitional assistance.

In addition to CMS' and SSA's outreach efforts, private PDPs and MA-PDs will be doing extensive marketing for their products. Like CMS and SSA, the marketing materials will be prepared far in advance of release to meet CMS' approval.

During the discount card period, the State Solutions National Program Office sought guidance from CMS about whether the limitations on drug card sponsors to restrict their marketing materials to promoting the discount card only and not other products or services also precluded them from including information on MSPs. While we were unable to get an official written response, CMS officials verbally indicated that card sponsors are allowed to integrate information on MSPs in their marketing materials but that none had opted to do so. Based on discussions with some discount card sponsors, few may have been aware of the MSPs or that they would be allowed to include this information. In fact, one card sponsor that was also a Medicare+Choice (M+C) plan indicated that CMS explicitly prohibits promoting MSPs in M+C promotional materials due to concerns that potential enrollees might interpret that these benefits would only be available to them if they enrolled in that particular M+C. Thus, outreach and education of potential Part D plans on the availability of MSP benefits may be needed.

Under Part D, PDPs and MA-PDs have more flexibility in marketing other products than during the discount card period. The final regulations allow PDPs to market additional "health-related" products that could provide additional tools to help beneficiaries manage their expenses and financial security. It is still unclear whether PDPs are allowed to promote MSP programs as a free benefit available to low-income Medicare beneficiaries, but the allowance that PDPs and MA-PDs may market other products may represent an opportunity for MSP promotion since the MSPs certainly serve as a benefit that lowers Medicare beneficiaries' expenses, thereby helping to maintain their financial security. Further guidance and confirmation by CMS on this issue is needed.

Facilitating MSP Enrollment at Part D Low-Income Subsidy Application

For its fiscal analysis, CMS estimated that 10.9 million Medicare beneficiaries out of the 14.5 million who are eligible will enroll in the Part D low-income subsidies. Excluding the full benefit duals who are already enrolled in Medicaid (6.3 million), this means that 4.6 million additional low-income Medicare beneficiaries will be identified and enrolled through Part D who may not yet have been reached by the MSPs but could potentially be eligible.[6]

Requiring SSA to Screen for MSPs

When an individual applies for Part D low-income subsidies, the MMA requires State Medicaid agencies to screen for eligibility in other low-income programs including the MSPs. This screening requirement for Medicaid agencies has the potential to increase enrollment in MSPs but only to the degree that those applying for Part D low-income subsidies do so through the Medicaid agency. SSA is not required to screen for these additional benefits. Thus, depending on how Medicare beneficiaries apply for the Part D low-income subsidies, they may or may not be made aware of the complementary MSP benefit that is also available to them.

With no new funding for expanded eligibility determination responsibilities beyond federal financial participation (FFP) under Medicaid, State Medicaid agencies are concerned about increased administrative costs for Part D eligibility determination at a time when most states are facing significant budget deficits. While the law requires that states must have the ability to determine eligibility for Part D subsidies if someone requests one, the final regulations allow states to provide applicants with the SSA application which they can forward to SSA to perform the eligibility processing role for these individuals. While states are still obligated to screen for MSP eligibility and offer enrollment to individuals applying for the low-income subsidy**,** it is unclear whether they will do so.[7] If not, since SSA is not required to screen for other low-income benefits, the opportunity to expand MSP enrollment through the Part D screening process could be lost.

As CMS appears to be moving toward a model where SSA is the primary site for eligibility determination, it is critical that SSA also be required to screen for QMB/SLMB/QI-1s. In its impact analysis on state costs, CMS estimates that if screening is done through the state Medicaid agencies, 1.1 million persons will be screened and found eligible for Medicaid or QMB/SLMB - of these, CMS estimated 21 percent (231,000) would receive full Medicaid benefits, 20 percent (220,000) would receive QMB benefits, and 59 percent (649,000) would receive SLMB benefits.[8] While this increase is considerable, it is much lower than the number of persons who might be found eligible if SSA were also determining eligibility.

Congress has already statutorily required SSA to help increase enrollment in the MSPs by mailing outreach letters to all Medicare beneficiaries who are potentially eligible.[9] Requiring SSA to screen for

MSP eligibility under Part D would extend this responsibility further but would be in keeping with their extended eligibility determination role for low-income benefits under Part D.

An alternative to requiring SSA to screen for MSPs would be to develop a uniform application for both the Part D and QMB/SLMB/QI-1 benefits. A uniform application would require standardizing the eligibility criteria for the MSPs to be the same as those for the Part D full low-income subsidy benefit. Standardizing asset test requirements between the MSPs and the Part D full low-income subsidy benefit would simplify eligibility determination and thereby increase the likelihood that SSA might assume this function. To the degree that Medicaid's responsibilities for MSP intake and screening might be reduced as a result, state Medicaid agencies might be willing to contract with SSA to perform screening. Currently, Medicaid contracts with SSA to conduct intake on their behalf for SSI benefits, which could serve as a potential model for MSP screening. However, in states that have utilized more liberal asset tests, standardizing to the Part D income and asset criteria could reduce the number of persons eligible for MSPs in those states.

Providing LIS Data from SSA to States

Requiring SSA to screen for MSP may require statutory change. However, in the absence of a statutory requirement, CMS is working with SSA to design a process to provide states with information on persons determined to be Part D subsidy eligible who may also qualify for a MSP program. CMS expects that states will use this information to contact individuals who may qualify for assistance with Medicare cost sharing and to assist them in the application process for MSPs.[10] While not as efficient as having SSA screen for MSP eligibility, the availability of these new lists of potentially eligible persons represents an opportunity for identifying new MSP enrollees to the extent that states follow-up by contacting individuals. Since the nature of the information to be provided is still being determined, state officials or advocates who are interested in using this information may want to provide input into the process, including lessons learned from their historical experience using leads data from SSA. Anecdotal reports suggest that SSA would not have to provide states with their verified income and asset data, which means that states would need to take additional steps to obtain this information. Advocates see this as duplicative and burdensome and are pushing to have SSA automatically forward income and asset information to the states as well.[11]

Another alternative to SSA incorporating MSP information in outreach materials is for SSA to incorporate information on the MSPs in their low-income subsidy determination or re-determination notifications; informing LIS eligible persons below 135 percent of FPL that they may also be eligible for additional financial support in paying for Part B premiums. According to a news article in *Inside CMS*, SSA plans to give MSP-eligible beneficiaries a one-page document listing their income and asset data, which they can take to their Medicaid office for MSP eligibility determination.[12]

Modifying State Asset Rules to Meet or Exceed Part D Low-Income Subsidy Requirements

As has been described in a separate State Solutions brief, several states have moved to liberalize the asset criteria or disregard all assets in one or more of their MSP programs; using the state plan amendment process to minimize application barriers and reduce administrative costs. States that have not pursued this course may want to consider at least matching the higher asset standard set for the Part D low-income subsidies. Since state eligibility workers may be responsible for screening for both the Part D benefit and the MSPs, imposing the same asset test in both programs is likely to simplify the eligibility process, saving time for both staff and applicants and reducing administrative costs. As indicated above, standardization of asset test requirements across the two programs would also make screening for MSPs much easier, thus making it easy to argue that SSA should take on this responsibility along with states.

Working with State Pharmacy Assistance Programs (SPAPs)

Twenty three states currently have pharmacy assistance programs that assist a total of approximately 1.3 million low-income aged and/or disabled individuals in purchasing prescription drugs, most of whom are also Medicare beneficiaries and will be eligible for Part D benefits. Based on interviews with program directors in Spring 2004, many of these programs plan to continue in some form to supplement the Part D benefit.[13] While SPAP eligibility rules vary by state, the average income eligibility for these programs is 200 percent of FPL, and many of their enrollees will be eligible for the Part D LIS. Thus, all of these programs serve at least some individuals who are potentially eligible for MSP programs. Despite their overlapping target populations, only a few states have linked enrollment between SPAP and MSP programs to date.[14]

SPAP states have a strong financial incentive to get their members enrolled in Medicare Part D drug plans in order to offset current state expenditures and maximize federal dollars, particularly in light of state fiscal pressures. With a few exceptions, these programs are funded through state general funds or through other earmarked funds such as state lottery or tobacco settlement funds. States stand to gain the greatest savings from the generous Part D low-income subsidies which will cover the vast majority of prescription drug costs for many eligible SPAP enrollees. Since most SPAPs do not require an asset test, the exact number of SPAP enrollees who are eligible for Part D subsidies is unknown, but most states estimate that a large proportion of their members will be eligible for the partial or full subsidies. During the interim Medicare discount card program, approximately 46 percent of current SPAP enrollees were income eligible for transitional assistance totaling over half a million SPAP enrollees nationwide.[15] To assist SPAPs in transitioning their enrollees into Part D and the low-income subsidies, CMS has awarded them a total of $125 million in grants over the next two years to plan for the transition and educate their enrollees.[16]

The Part D low-income subsidy eligibility process as currently defined by the final Part D regulations may provide an impetus for SPAPs to coordinate more closely with the MSPs. Unlike MSP enrollees who are “automatically eligible” for Medicare Part D low-income subsidies, SPAP enrollees will need to apply

separately for these benefits either through SSA or a Medicaid agency.[e] This application process is required in addition to enrolling in a PDP or MA-PD.

This two-step Part D subsidy enrollment process differs from the streamlined application process used for the interim Medicare discount cards, in which enrollees could apply for the card and transitional assistance simultaneously. During the Medicare discount card program, SPAPs were allowed to autoenroll their members into a preferred discount card of the state's choice if the state had legal authority to act as the authorized representative and if enrollees were allowed to opt out.[17] The preferred discount card sponsor then submitted the files to CMS for transitional assistance eligibility verification thereby making the whole enrollment process into the discount card and the $600 credit transparent to SPAP enrollees. Autoenrollment of SPAP members into transitional assistance has been very successful by most states' accounts. The vast majority of eligible members were enrolled into transitional assistance and the states have recouped considerable savings as a result.[18]

However, getting current SPAP enrollees enrolled in a Part D plan and determined eligible for the low-income subsidies will be much more difficult. The final Part D regulations do not allow SPAPs to autoenroll into a preferred plan for the Part D benefit,[f] nor do they grant them the authority to determine eligibility for Part D low-income subsidies on behalf of SSA or Medicaid.[19] If they have the legal authority to act as their enrollees' authorized representative, SPAPs may apply for the LIS on their behalf. However, the process as currently defined would require them to complete and submit separate SSA applications for each of their enrollees. Even then, the draft SSA regulations do not indicate that the authorized representative will be sent notifications of eligibility determination. In cases where SSA denies eligibility, the state would not be notified and would not be able to appeal the decision on their enrollee's behalf. SPAPs are in the process of negotiating with SSA to allow them to utilize information from SPAP applications to minimize burden on enrollees and to submit electronic files for eligibility determination, but it is still unclear whether these requests will be granted.[g]

At the same time, there is little incentive for SPAP enrollees to apply for the LIS. Depending on the state, the Medicare low-income subsidy benefit may be only slightly more generous than the benefit provided through the state program, where the beneficiary is not required to provide confidential asset

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[e] In commenting on the draft regulations, several states and the SPAP Transition Commission recommended that SPAP agencies also be given the authority to determine eligibility for Part D low-income subsidies on behalf of SSA and/or Medicaid.

[f] Additional operational guidance released on April 5, 2005, may allow SPAPs to autoenroll members that have not voluntarily enrolled in a Part D plan by May 2005 into Part D plans. Rather than requiring random autoassignment across all plans, CMS is allowing SPAPs to do "intelligent random assignment" which would allow states to randomly assign enrollees only into those plans that met specific criteria set by the state and approved by CMS. Source: CMS. Auto-Enrollment and Facilitated Enrollment of Low-Income Populations. April 5, 2005.

[g] In meetings with SPAP directors, CMS has expressed a willingness to develop a mechanism to submit batch file applications to SSA on behalf of the SPAPs to facilitate their enrollment in the low-income subsidies. Further guidance on this process is forthcoming.

information.[h] Unless states mandate Medicare enrollment as a condition of SPAP eligibility, SPAP enrollees are unlikely to voluntarily disclose asset information to enroll in a subsidy program where the benefit is primarily accrued to the state, not the individual enrollee.[i]

Since MSP enrollees are automatically eligible for low-income subsidies, SPAPs have a clear incentive to identify which of their enrollees are already in the MSP programs to eliminate the additional step of applying for the low-income subsidies. To guarantee that the federal Part D subsidies are in place effective January 2006, SPAPs states may also be more open to performing in-reach to their current SPAP enrollees to increase enrollment into the MSPs.

Two successful models for linking MSP and SPAP programs in Minnesota and New Jersey have been described in a previous State Solutions issue brief.[20] By linking these programs, these two states already have a jump start in ensuring that a large proportion of their low-income SPAP enrollees will get the Part D low-income subsidies. For example, one third of New Jersey's Pharmaceutical Assistance for the Aged and Disabled program (PAAD) enrollees estimated to qualify for the full low-income subsidies, are already enrolled in SLMB or QI-1. In fact, the state is already preparing to contact these enrollees to gather updated asset information so that they will be deemed automatically eligible for the low-income subsidies as soon as eligibility determination begins in July 2005. In addition, NJ is trying to identify the remaining PAAD enrollees who might be eligible but are not enrolled in SLMB/QI-1. Going forward, they plan to develop a uniform PAAD, SLMB/QI-1, and SSA Part D low-income subsidy application. They will send the new application to PAAD enrollees with incomes under 135 percent of FPL as soon as possible as an early recertification, requesting enrollees to voluntarily provide asset information with the incentive that they may be eligible for assistance in paying their Part B premiums.

While identification of new MSP enrollees will require additional state commitments, the modest increase in state expenditures to buy-in to Medicare for these beneficiaries will be greatly offset by the savings to the state as a result of automatic eligibility for SPAP enrollees in the low-income subsidies.[j] In addition, the systems-related costs of coordinating these two programs in order to facilitate the transition of SPAP enrollees into Medicare Part D could potentially be covered by SPAP transitional assistance grants.

The converging incentives to maximize MSP enrollment in SPAPs may even result in some SPAP states supporting other MSP eligibility expansion and administrative simplification initiatives.[21] In order to ensure that the greatest number of SPAP enrollees are also enrolled in MSPs and thereby autoenrolled in

[h] Only 2 SPAPs have asset test requirements. Other states that have attempted to impose asset tests have faced strong opposition.

[i] The lower cost-sharing requirements in the Part D low-income subsidies compared to cost-sharing in nearly all of the SPAP programs does provide some incentive for individuals to enroll. But particularly in states with very generous benefits, the modest savings may not be sufficient to convince them to go through a cumbersome application process.

[j] States that have expanded full Medicaid benefits to QMBs and/or SLMBs are less likely to see any savings and may incur greater costs.

Part D subsidies, these states may be open to pursuing state plan amendments to allow self-declaration of assets or disregard all assets within their MSP programs. Under the final regulations CMS imposed a federal asset standard for the Part D low-income subsidies rather than allowing discretion for state-specific asset criteria as offered in the statute. However, by deeming MSP enrollees automatically eligible for Part D, states with more liberal asset test requirements can circumvent the federal standard, thereby making a greater number of their SPAP enrollees that are also enrolled in MSPs eligible for the generous LIS benefits.[22]

Working with PDPs, Medicare Advantage, and Special Needs Plans

Even if PDPs and MA-PDs are precluded from including MSP information in their marketing materials for Part D, there may be economic incentives for them to maximize MSP enrollment among their members once they are enrolled depending on the risk adjustment payment rules under the final regulations. Risk adjusting payments helps to ensure that plans which serve sicker beneficiaries are paid more than plans with healthier patients in the same area. The initial risk-adjustment payment methodology for M+Cs, which was based on demographic factors including Medicaid (and QMB/SLMB/QI-1) coverage, created strong incentives for M+Cs to identify members who are MSP-eligible and get them enrolled.[23] By enrolling their members into MSPs and particularly into the QI-1 program, where enrollees' costs were likely to be lower due to their higher incomes, M+C were able to receive the higher payment rate to serve clients who were likely to have lower costs than full duals who are typically sicker. In fact, several states that we spoke with indicated that enrollment broker agencies working on behalf of M+C plans to identify and enroll their members into MSPs had attained significant increases in MSP program enrollment. Efforts by one brokering agency in Oregon were so successful that they reached the enrollment cap for the QI-1 program.

Payments to the new Medicare Advantage plans will also be risk adjusted. However, the new methodology being phased in by 2007 will adjust risk based on health status as measured by diagnoses on hospital and ambulatory care records, rather than on demographics alone. In the interim they will use a blended method of 70 percent demographics and 30 percent health status in 2004, 50/50 in 2005, and 25/75 in 2006.[24] Thus, there is only a small window of opportunity to take advantage of this economic incentive with the MA plans.

Similarly, the payments for the newly created PDPs will also be risk adjusted and that methodology has not yet been finalized. Since there is little historical data to draw from and since CMS is eager to encourage private companies to offer PDPs, plans are likely to have a generous risk adjustment up front. To avoid discouraging plans from enrolling persons eligible for low-income subsidies, the methodology may even overcompensate for these beneficiaries. If this is the case, PDPs, like the SPAPs, would have a strong interest in identifying MSP eligibles within their enrollment and getting them automatically eligible for the subsidies, just as M+Cs have in the past.

The creation of MA Special Needs Plans (MA-SNPs) may also present an opportunity to expand MSP enrollment to the degree that current managed care plans are "redesignated" as a special needs plan. Section 231 of the MMA allows MA organizations to offer plans that serve special needs individuals. Pending final regulations, MA-SNPs must serve all dual eligibles including those entitled to Medicare Part A and Part B and full Medicaid benefits, QMBs, SLMBs, and QI-1s.[25] Generally, all individuals enrolled in a SNP must have Medicaid (including QMB/SLMB/QI-1) in order to be eligible. However, under the current guidelines, an existing MA plan that has some dual eligible or institutionalized enrollment may request redesignation as a special needs plan. In these cases, these organizations would have an interest in enrolling any of their members potentially eligible but not currently enrolled in Medicaid or MSPs to maintain them in the MA-SNP. If CMS pays organizations equally for all dual eligibles regardless of whether they are full benefit dual eligibles or those with higher incomes enrolled in MSPs, MA-SNPs may have an economic incentive to include MSP enrollees whose costs are likely to be lower than the full duals. [26]

Conclusion

The availability of Part D prescription drug coverage under Medicare is one of the largest expansions in the Medicare benefit since its inception. Thus, it represents an ideal opportunity to promote complementary subsidy programs intended to help people enroll in Medicare such as the MSPs. This issue brief is intended as a springboard for discussion of how this is best accomplished. While we have discussed several options, we believe that the opportunities that are likely to yield the greatest MSP enrollment increases are those where enrolling persons in MSPs also has benefits to collaborating partners, particularly the SPAPs and potentially the SNPs to the degree that risk adjustment favors low-income enrollees. Requiring SSA to screen for MSPs also has the potential to significantly increase enrollment, but will require a change in statute. To some extent, some of these opportunities are reliant on decisions still to be made by CMS. Future issue briefs will review final operational guidance and the implications for MSPs and will also investigate various public/private partnerships in maximizing MSP enrollment through the Part D benefit in more detail.

Endnotes

[1] Federal Register, Agency Information Collection Activities: Proposed Request and Comment Request, Volume 69 No. 189, September 30, 2004.

[2] Centers for Medicare and Medicaid Services (CMS). 42 CFR Parts 403, 411,417, and 423 Medicare Program; Medicare Prescription Drug Benefit; Proposed Rule. Federal Register, Volume 69, No. 148, August 3, 2004, p. 46727; and CMS, 42 CFR Federal Register, Volume 70 No. 18, January 28, 2005, p. 4369.

[3] CMS. Auto-Enrollment and Facilitated Enrollment of Low-Income Populations. April 5, 2005.

[4] CMS. 42 CFR, Federal Register, Volume 69 No. 148, August 3, 2004, p. 46642.

[5] United States General Accounting Office. *Medicare Savings Programs: Results of Social Security Administration's 2002 Outreach to Low-Income Beneficiaries*. March 2004.

[6] CMS. 42 CFR. Federal Register, Volume 70 No. 18, January 28, 2005, p. 4459.

[7] CMS. 42 CFR. Federal Register, Volume 70 No. 18, January 28, 2005, pp. 4418-19. CMS, *Savings for States and More Help for the Beneficiaries They Assist*. Issue paper published 7/29/04. Accessed at: http://www.cms.hhs.gov/medicarereform/issuepapers/title1and2/files/issue_paper_04_-_savings_for_states_and_more_help_for_the_beneficiaries_they_assist.pdf on 11/15/04.

[8] CMS. 42 CFR, Federal Register, Volume 70 No. 18, January 28, 2005, p. 4485.

[9] Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) Pub. L. No. 106-554. App. F, Section 911 (a), 114 Stat. 2763A-583 (adding section 1144 to the Social Security Act, codified at 42 USC Section 1320b-14 (2000)).

[10] CMS. 42 CFR, Federal Register, Volume 70 No. 18, January 28, 2005, p. 4382.

[11] Advocates Press SSA to Share Income, Asset Data for MSP Screening. *Inside CMS*, February 24, 2005.

[12] Ibid.

[13] Fox K, Crystal S. *Coordinating Medicare Prescription Drug Benefits with State Pharmacy Assistance Programs.* Report funded by Commonwealth Fund. New Brunswick, NJ: Rutgers Center for State Health Policy; April 2005.

[14] Blume R. *Linking State Prescription Programs with Medicare Savings Programs: Examples from New Jersey and Minnesota*, State Solutions Issue Brief. New Brunswick, NJ: State Solutions National Program Office; March 2004.

[15] Fox K. "Coordination of Benefits between State Pharmaceutical Assistance Programs and Medicare Part D Pharmacy Benefits: Implementation Concerns and Alternatives." Testimony for State Pharmaceutical Assistance Transition Commission (SPATC), Washington, DC, July 7, 2004.

[16] "HHS announces awards to states to tell low-income beneficiaries about 2006 drug benefit." DHHS Press Release, October 28, 2004.

[17] "Medicare Makes Drug Card Enrollment Easier with Autoenrollment and Standard Form." CMS Press Release, April 17, 2004.

[18] Fox and Crystal, 2005.

[19] States Cannot Fill-in Donut if They Discriminate Between Plans. *Inside CMS.* Volume 7 No. 23, November 4, 2004.

[20] Blume, 2004.

[21] Tiedemann A, Fox K. *Promising Strategies for Medicare Savings Program Enrollment: Modifying Eligibility Criteria and Documentation Requirements.* State Solutions Issue Brief. New Brunswick, NJ: State Solutions National Program Office. November 2004; Summer L. *Administrative Costs Associated with Enrollment and Renewal for the Medicare Savings Programs in Louisiana.* Internal State Solutions memo; 2004.

[22] Drug Rule Appears to Give Some Residents Back-Door Access to Subsidy*, Inside CMS.* Volume 7 No. 16, July 29, 2004.

[23] Chaikind HR, Morgan PC. *Report for Congress: Medicare+Choice Payment.* Congressional Research Service. Updated January 22, 2003.

[24] CMS. *Questions for Q and A on Title II (Medicare Advantage) Regulation.* Accessed from CMS website at http://www.cms.hhs.gov/medicarereform/TitleII.pdf on November 11, 2004.

[25] CMS. *Interim Guidance Regarding MA Special Needs Plans for Dual Eligibles and Institutionalized Individuals.* Accessed from CMS website at http://www.cms.hhs.gov/healthplans/specialneedsplans/qaspecneeds06-23.pdf on November 11, 2004.

[26] Ibid.

State Solutions

The Medicare Savings Programs are publicly financed programs that help people pay for costs associated with Medicare, such as premiums, co-payments and deductibles. It is estimated that 5 million people are eligible to receive financial help through the Medicare Savings Programs, but only half are enrolled. Eligibility is generally granted to Medicare enrollees with low incomes, including people with disabilities and seniors.

State Solutions is a national program working to increase enrollment in and access to the Medicare Savings Programs. Funding for State Solutions is provided by The Robert Wood Johnson Foundation and The Commonwealth Fund.