State Solutions

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# Accomplishments and Lessons from the State Solutions Initiative To Increase Enrollment in the Medicare Savings Programs

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## *Executive Summary*

The State Solutions project, sponsored by The Robert Wood Johnson Foundation and The Commonwealth Fund, is an initiative to improve enrollment in the Medicare Savings Programs (MSP), which provide some financial assistance to low-income Medicare beneficiaries who are not eligible for full Medicaid coverage. The State Solutions National Program Office at the Center for State Health Policy at Rutgers University administers the project. Beginning in July 2002, grantees in five states – Louisiana, Minnesota, New Hampshire, New York, and Pennsylvania – received awards to conduct activities to boost MSP enrollment over a three-year period. This report describes State Solutions program activities for which there is enough information to draw conclusions about the success of efforts and to make recommendations regarding future activities to increase enrollment in both the Medicare Savings Programs and in the new low-income subsidy program for Medicare Part D.

### Activities to identify, reach, and enroll potential program participants

State Solutions grantees used a variety of approaches to identify, reach, and enroll potential program participants. There were several mass mailings based on data that states received from the Social Security Administration. Grantees also used data from other programs, such as state pharmacy assistance programs, to target outreach efforts. In other instances, individuals receiving benefits such as public housing or home delivered meals were contacted and told about the Medicare Savings Programs. Community leaders also worked with grantees to spread the word about the Medicare Savings Programs and to help with enrollment.

In some instances, grantees were able to track the number of calls for information, requests for help, applications sent to potential participants, applications returned, and individuals enrolled in the Medicare Savings programs.

An examination of the practices and outcomes leads to the following conclusions:

- The use of data from similar programs to identify and facilitate the enrollment of potential MSP beneficiaries can be particularly effective.
- Generally, the effectiveness of mass mailings is limited, with very small proportions of beneficiaries responding to numerous mailings in State Solutions states.
- If mass mailings are used, the data on which they are based should be as specific as possible with regard to eligibility criteria.
- To be most effective at eliciting a response, mass mailings should be tailored, with specific information about who to contact locally and how to apply for benefits.
- Attention-getting formats appear to work in some instances. Frequency of communication may also be helpful in gaining attention.
- It is important to determine the extent to which the target population is already enrolled in a program before committing substantial resources to outreach.
- People respond to trusted information sources; the involvement of community leaders and organizations is particularly important.

**Activities geared to changing policy**

Activities to identify and reach potential program participants are an important part of efforts to increase enrollment in the Medicare Savings Programs, but they are not sufficient to guarantee enrollment increases. Even if people are aware of and in need of program benefits they may not complete the application process if it is too onerous. Also, enrollment will be negatively affected if eligible program participants do not renew their benefits successfully and on time because the renewal process poses problems. Some policy changes have the potential to simplify the enrollment and renewal process and therefore, to increase program participation significantly. For example, eliminating requirements for verification documents, lengthening eligibility periods, amending rules related to estate recovery, making changes to the process used to pay Medicare Part A premiums for some individuals can play a role in increasing program enrollment.

Conclusions based on State Solutions grantees' efforts to change MSP policy are presented below:

- Policy changes regarding the methods for counting and documenting asset values appear to have a positive impact on enrollment.
- Policies to simplify the renewal process promote enrollment by reducing the number of beneficiaries who lose benefits at renewal for procedural reasons such as failure to return forms or to provide documents.
- Policy changes to simplify the enrollment and renewal processes can also achieve some administrative savings.
- Annual rather than more frequent renewal requirements can have a positive impact on enrollment and achieve administrative savings.
- Changes in state purchasing policies related to Medicare Part A premiums can increase MSP enrollment, and can promote savings for the state.
- The routine collection and use of data regarding not only program enrollment, but also application and renewal outcomes, is very helpful in showing whether efforts to increase enrollment have been successful and in demonstrating whether certain policy changes would be helpful. For example, some states report regularly on the proportion of MSP case closures for procedural reasons and on the specific reasons for closure.

**Efforts to understand and improve the outcomes of activities to increase enrollment**

Several of the State Solutions grantees examined outreach activities in order to make improvements if necessary. Specifically, several attempted to track applications submitted as a result of particular outreach activities. Also, some grantees held focus groups or consumer satisfaction surveys to elicit opinions about effective outreach techniques.

Two important lessons emerged from State Solutions grantees' efforts to understand and improve outreach outcomes.

- Direct feedback from current and potential beneficiaries is an important first step in planning outreach efforts.
- The effectiveness of methods to track responses to outreach activities may be limited by coding problems. Sufficient training regarding not only the new coding system, but also the reasons for changing the system will improve adherence.

**Conclusion**

Enrollment increased in the Medicare Savings Programs in all five states participating in the State Solutions project over the three-year period of the project. Many factors contributed to the increases, but efforts on the part of the five grantees likely played an important role. Outcome data suggest that

outreach efforts were most successful when they were carefully targeted to individuals who meet the program eligibility criteria and when they included specific information about how and where to get help. Efforts to understand the application process from the beneficiaries' perspective also helped grantees develop strategies to improve program operations. A range of policy changes, which resulted in simpler application and renewal processes, also were helpful in boosting enrollment. The need to reach and enroll low-income Medicare beneficiaries in the Medicare Savings Programs as well as in the Medicare Part D low-income subsidy program persists. Lessons from the State Solutions project are relevant as state programs and other organizations in states strive to ensure that low-income beneficiaries receive the benefits they need.

## *Introduction*

The State Solutions project, sponsored by The Robert Wood Johnson Foundation and The Commonwealth Fund, is an initiative to improve enrollment in the Medicare Savings Programs (MSP), which provide some financial assistance to low-income Medicare beneficiaries who are not eligible for full Medicaid coverage (see Table 1). A substantial portion of those who are eligible to receive financial help through the Medicare Savings Programs are not enrolled.

The State Solutions National Program Office at the Center for State Health Policy at Rutgers University administers the project. Beginning in July 2002, grantees in five states received awards to conduct activities to boost MSP enrollment over a three-year period. In two states, Louisiana and Minnesota, the grants went directly to the departments that administer the Medicare Savings Programs, the Louisiana Department of Health and Hospitals and the Minnesota Department of Human Services. In three states, grants went to coalitions of private and government groups: the Community Services Council of New Hampshire, the Medicare Rights Center in New York, and the Pennsylvania Health Law Project.
This report describes State Solutions program activities for which there is enough information to draw conclusions about the success of efforts and to make recommendations regarding future activities. Three types of activities undertaken by the grantees are described:

- activities to identify and enroll MSP participants;
- activities to change program policies;
- activities to understand and improve the outcomes of efforts to increase enrollment.

Lessons from the State Solutions project should be helpful as states consider how to increase enrollment for the Medicare Savings Programs and for the low-income subsidy (LIS), or "Extra Help" available for the new Medicare Part D benefit.

***Table 1: Financial Eligibility Criteria and Benefits for the Medicare Savings Programs****

| **Program** | **Countable Income Limits**** | **Countable Asset Limits** | **Benefits** |
|---|---|---|---|
| Qualified Medicare Beneficiary (QMB) | At or below 100% of the federal poverty line | $4,000 for an individual<br>$6,000 for a couple | Medicaid pays all Medicare Part B premiums ($88.50 per month in 2006) and cost-sharing charges |
| Specified Low-Income Medicare Beneficiary (SLMB) | Between 100% and 120% of the federal poverty line | $4,000 for an individual<br>$6,000 for a couple | Medicaid pays Medicare Part B premiums ($88.50 per month in 2003) |
| Qualifying Individuals (QI) | Between 120% and 135% of the federal poverty line | $4,000 for an individual<br>$6,000 for a couple | Medicaid pays Medicare Part B premiums ($88.50 per month in 2003) |

* Standard income and asset eligibility criteria are presented here. In counting income or resources, however, states may also use methods that are "less restrictive" than those specified for the Medicaid, QMB, SLMB, and QI programs. In those instances, income and asset limits are higher than those specified in this chart.

** In 2006, the federal poverty line is $9,800 for individuals and $13,200 for couples.

### *Activities to identify, reach, and enroll potential program participants*

State Solutions grantees used a variety of approaches to identify, reach, and enroll potential program participants. Federal mandates for the Social Security Administration (SSA) to contact individuals potentially eligible for the Medicare Savings Programs and to provide the Centers for Medicare & Medicaid Services (CMS) with information about beneficiaries' income status formed the basis for outreach efforts in some states. Data from other programs, such as state pharmacy assistance programs, also have been used to target outreach efforts. In other instances, individuals receiving benefits such as public housing or home delivered meals were contacted and told about the Medicare Savings Programs. Community leaders also worked with grantees to spread the word about the Medicare Savings Programs and to help with enrollment.

State Solutions grantees attempted to measure the outcome of some of these outreach efforts. Ideally, the success of outreach activities should be measured using enrollment data. The most conclusive measure is an examination of enrollment figures before and after the effort. But appropriate enrollment figures are not always available. Success also can be measured to a certain extent by tracking the number of calls or other inquiries for information following an outreach activity. Some callers may not be eligible for benefits and some may not apply, but even they will be more aware of the program and may spread the word to other potential enrollees. Other measures that grantees used to provide an indication of whether outreach activities likely had an impact include the number of applications sent to prospective applicants and the number of applications submitted.

**Medicare Savings Programs and the Medicare Part D Low-Income Subsidy**

The new Medicare Part D Prescription Drug Plan became available in January 2006. Subsidies to help low-income Medicare beneficiaries with the cost of premiums and copayments for the drug plan also are available. The subsidies are also called "Extra Help." The financial eligibility criteria for the subsidies are similar to the criteria for the Medicare Savings Programs. In addition, individuals receiving MSP benefits automatically qualify for the low-income subsidies. Low-income Medicare beneficiaries who are not already enrolled in the Medicaid program or in Medicare Savings Programs must apply for subsidies either at state Medicaid offices or through the Social Security Administration. State Medicaid programs are required to screen and enroll low-income subsidy applicants for Medicaid and MSPs as well. Although the same screening requirements do not apply when applications are processed through the Social Security Administration, there is great potential for referrals to state Medicaid offices and for information sharing to streamline the income and asset verification processes. Processing applications for the subsidy, as well as responding to Medicare beneficiaries' questions about the subsidy and the new benefit, are added administrative functions for state and local Medicaid offices, which already have limited resources. Information about methods to simplify the enrollment and renewal processes for the Medicare Savings Programs is relevant to the Medicare Part D low-income subsidy as well.

**Using data from the Social Security Administration**

Income data from the Social Security Administration have been used in efforts to identify individuals who potentially are eligible for the Medicare Savings Programs. Social Security records do not have information on resources or other income sources, however, so the SSA data are a "first cut." Not all individuals identified will be eligible for MSP benefits, but because many low-income beneficiaries are not likely to have other sources of income or substantial resources, the SSA data can help identify individuals who potentially are eligible for the Medicare Savings Programs.

*SSA National Direct Mail Campaigns*

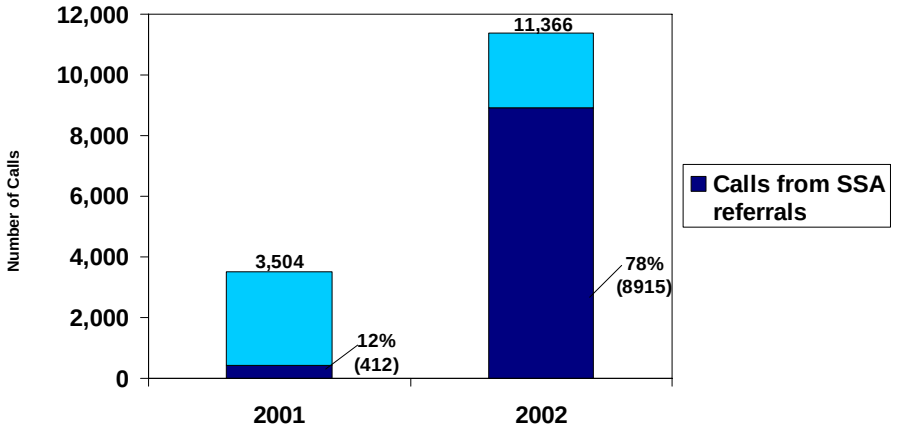
The Benefits Improvement and Protection Act of 2000 requires that the Social Security Administration review income data annually and directly contact low-income Medicare beneficiaries about their potential eligibility for Medicare Savings Programs. Letters are sent to Medicare beneficiaries whose Social Security incomes are less than 100 percent of the federal poverty level.

In 2002, SSA sent letters to more than 16 million Medicare beneficiaries. The U.S. General Accounting Office, in an analysis of these mailings, estimated that more than 74,000 or 0.5 percent, additional eligible beneficiaries enrolled in MSP than would have likely enrolled without the letter.[1] Three of the states participating in the State Solutions projects were included in the GAO's analysis of the results of the 2002 SSA mailings. According to GAO's findings, MSP enrollment increased more than it would have without the SSA letter by 0.9 percent in Louisiana, 0.3 percent in New York, and 0.4 percent in Pennsylvania.

In Minnesota, where calls to the *Senior Linkage Line*, part of the state's health insurance assistance program, are tracked, the volume of calls requesting information about the Medicare Savings Programs was more than three times as high in 2002, after the mailing, than in 2001 as a result of the referrals from SSA (see Figure 1).

Figure 1

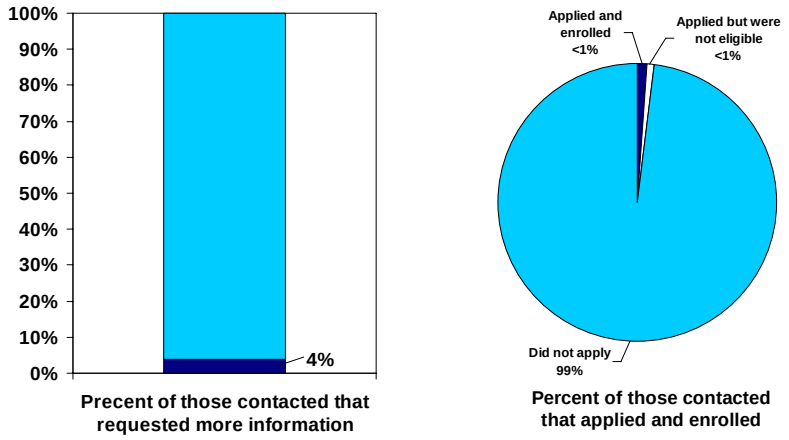
**Calls to the Minnesota Senior LinkAge Line Regarding the Medicare Savings Programs**




Source: Georgetown University Health Policy Institute calculations based on data from the Minnesota Senior LinkAge Line.

SSA mailings were also sent out in 2003 and 2004. These mailings did not include state-specific phone numbers as the 2002 mailing had, however. In 2002, Louisiana tracked the number of calls received to their hotline regarding the outreach letters and the number of applications sent to callers. Applications were color coded, enabling the state to determine the number of applications returned and the number certified for enrollment as a result of the SSA mailings. Applications were mailed to 10,866 callers. The proportions of applications returned and individuals enrolled in the Medicare Savings Programs were less than one percent (see Figure 2).

**Figure 2**
**Response to 2002 "Leads" Data Mailing in Louisiana**
(Potential participants contacted = 260,137)




Source: Georgetown University Health Policy Institute calculations based on data from the Louisiana Department of Health and Hospitals.

**SSA "Leads" Data**

On a monthly basis, the Social Security Administration also sends CMS a state-specific list of Medicare beneficiaries whose Social Security incomes are less than 100 percent of the federal poverty level. States may request these "leads" data from CMS for their own use each month in order to target outreach to individuals who may be eligible for other programs.

*Louisiana uses "leads" data to recruit program participants*

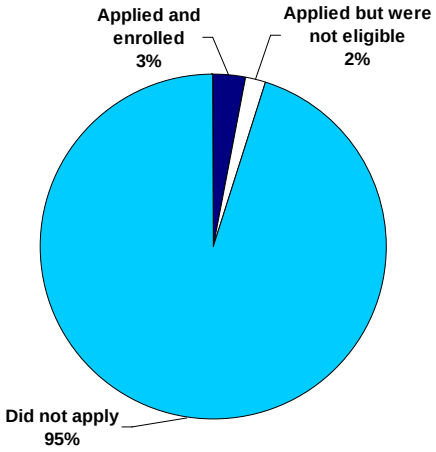
In 2003, Louisiana used leads data to identify the five regions in the state with the largest number of potential enrollees. The state sent one page (double-sided) flyers included in circular mailings, to more than 80,000 residents in the five regions. The total cost of these mailings was just over $2,000. Response to the mailings was low – the state only experienced a slight increase in calls to its hotline in the months following the mailing.

Early in 2004, the Monroe and Lafayette regions in Louisiana used the "leads" data in a more specific manner. They compared "leads" data with the data system used to make eligibility decisions for Medicaid and the Medicare Savings Programs in Louisiana. Flyers were sent only to those on the "leads" list who were not currently receiving MSP benefits. Less than three percent of those contacted enrolled in the Medicare Savings Programs in each region (see Figures 3 and 4).

**Figure 3**

**Response to 2004 "Leads" Data Mailing in Louisiana's Monroe Region**

(Potential participants contacted = 5,635)

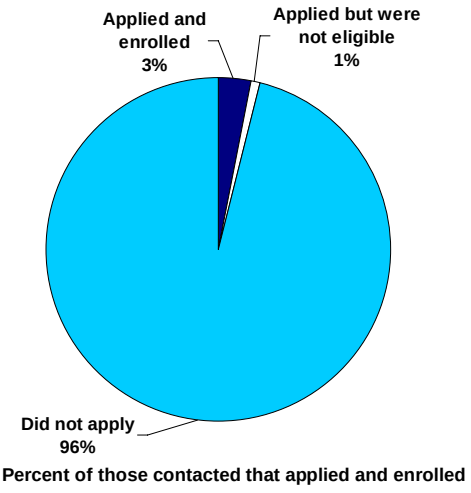



Source: Georgetown University Health Policy Institute calculations based on data from the Louisiana Department of Health and Hospitals.

**Figure 4**

**Response to 2004 "Leads" Data Mailing in Louisiana's Lafayette Region**

(Potential participants contacted = 5,231)



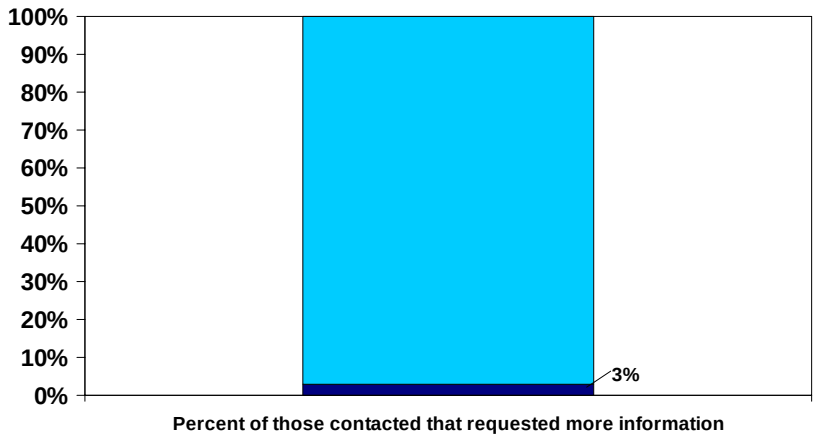

Source: Georgetown University Health Policy Institute calculations based on data from the Louisiana Department of Health and Hospitals.

In May and June 2004, the state used a similar process to identify individuals in the other regions of the state who were potentially eligible for MSP benefits, but not participating. About three percent of those receiving flyers called the MSP toll-free number to request additional information (see Figure 5).

**Figure 5**

**Response to 2004 "Leads" Data Mailing in Louisiana**

(Potential participants contacted = 86,000)




Source: Georgetown University Health Policy Institute calculations based on data from the Louisiana Department of Health and Hospitals.

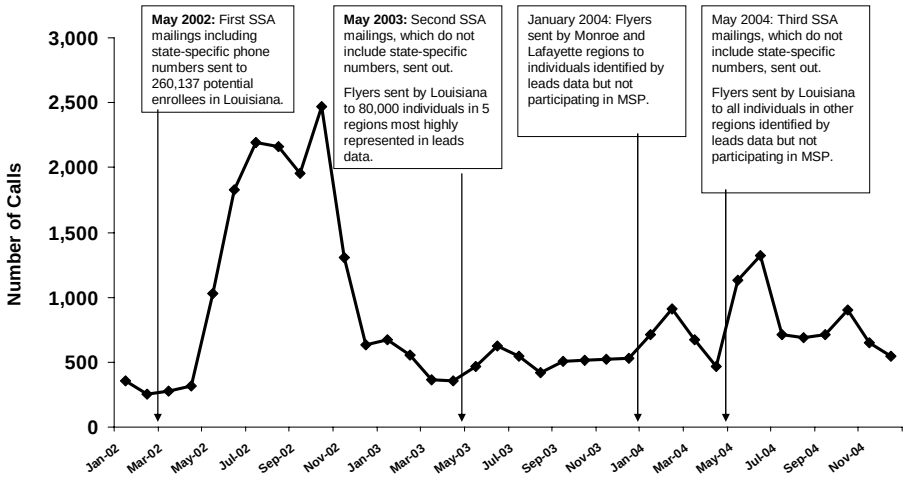
Data from Louisiana's information hotline do show that mailings have an impact on the number of requests for program information. There was a marked increase, for example, in call volume after the 2002 SSA mailing, which included the information phone number, and smaller increases after subsequent mailings (see Figure 6). Other data from Louisiana suggest that mass mailings are not a particularly effective means of recruiting enrollees, however.

*Minnesota also uses "leads" data*

In 2004 Minnesota conducted a mailing based on "leads" data, sending letters to 500 seniors and 500 people with disabilities. Each received a brochure and a cover letter in an envelope marked with a fluorescent sticker. One quarter of the letter recipients called the *Senior Linkage Line* for more information and more than one-fifth enrolled in the Medicare Savings Programs (see Figure 7).

Figure 6

## Calls to Louisiana Information Hotline

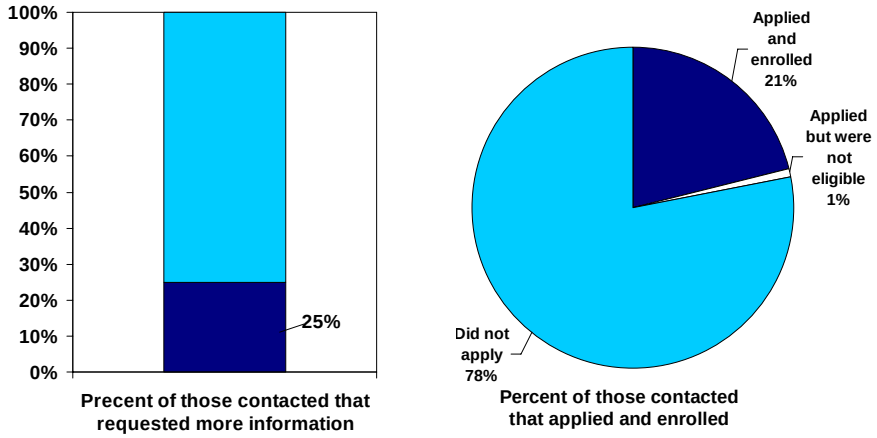



Source: Georgetown University Health Policy Institute calculations based on data from the Louisiana Department of Health and Hospitals.

Figure 7

## Response to 2004 "Leads" Data Mailing in Minnesota

(Potential participants contacted = 1,000)




Source: Georgetown University Health Policy Institute calculations based on data from the Minnesota Department of Human Services

**Using data from other programs to screen for MSP eligibility and target outreach**

Some grantees use data from other public benefit programs to identify potential MSP enrollees. This is an efficient approach since individuals already have been screened for financial eligibility. In addition, this strategy offers endorsement of MSP by a program that potential enrollees already know.

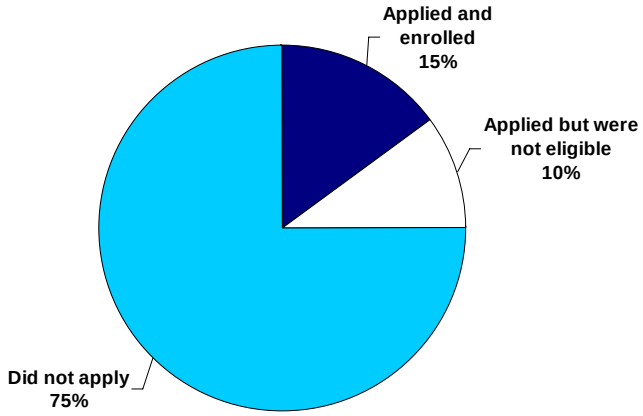
*Collaboration in Pennsylvania with the PACE and PACENET Programs*

The Pennsylvania State Solutions project collaborated with PACE and PACENET, the state's pharmaceutical assistance programs for seniors, to screen applications to the program for potential MSP eligibility. During the four month pilot program, which began in April 2004, some 1,745 of the 9,000 PACE applicants that were screened appeared eligible. These individuals were sent MSP applications that were pre-populated with the relevant information that had initially been submitted to the state pharmacy programs. A letter from PACE and PACENET describing the Medicare Savings Programs and a postage pre-paid return envelope also were sent. One-quarter of the applications were returned, and about 15 percent of those contacted received MSP benefits (see Figure 8).

Figure 8

**Response to 2004 PACE/PACENET Mailing in Pennsylvania**

(Potential participants contacted = 1,745)




**Percent of those contacted that applied and enrolled**

Source: Georgetown University Health Policy Institute calculations based on data from the Pennsylvania Health Law Project.

*Minnesota requires coordination between MSP and the state pharmacy program*

Minnesota's Prescription Drug Program was designed to require participation in the QMB or SLMB program as well. One application form – the Health Care Programs application – was used for both programs. Eligibility for the Medicare Savings Programs was determined first and then newly enrolled QMB and SLMB participants received a letter describing the Prescription Drug Program and offering enrollment. Anecdotal evidence from program staff indicates that interest in the Prescription Drug Program brought many people into the Medicare Savings Programs as well.[2]

**Contacting participants in other programs that serve similar populations**

In addition to screening applications to other programs with eligibility requirements similar to the MSP, states can try to reach new beneficiaries by contacting individuals already participating in programs that serve similar populations.

*Medicaid records yield new MSP enrollees in Minnesota*

As part of the State Solutions project, Minnesota's Department of Human Services examined Medicaid program data to identify all "dual eligible" individual – those who already participated in both Medicare and Medicaid – but did not participate in the QMB, SLMB or QI programs. The majority of those individuals did not qualify for the Medicare Savings Programs. Generally, they had qualified for Medicaid through special programs with different income and asset limits and so were not eligible for the MSP. Almost 1,100 of the dually eligible beneficiaries were determined to be eligible for the Medicare Savings Programs, however. The state agency informed instructed county workers to enroll each eligible individual in the appropriate Medicare Savings Program and continued to run monthly reports to ensure that eligible individuals already dually enrolled in the Medicare and Medicaid programs also received MSP benefits.

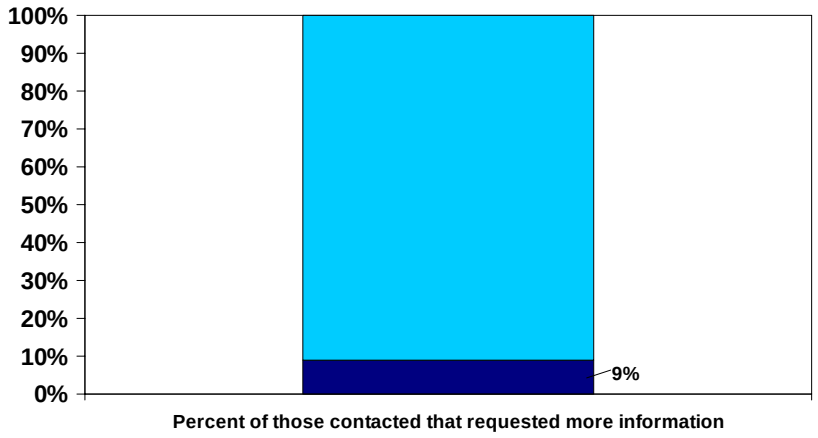
*PACE and PACENET participants are contacted in Pennsylvania*

Prior to the more extensive efforts to screen and enroll PACE and PACENET participants in the Medicare Savings Programs, the Pennsylvania State Solutions project collaborated with the state pharmacy programs to send outreach letters to potential participants. In February 2003, letters were sent to 4,444 PACE and PACENET beneficiaries in zip codes identified by census data as having high proportions of low-income beneficiaries. These letters had a nine percent response rate, generating 410 phone calls for additional information (see Figure 9).

Figure 9

**Response to 2003 PACE/PACENET Mailing in Pensylvania**

(Potential participants contacted = 4,444)




Source: Georgetown University Health Policy Institute calculations based on data from the Pennsylvania Health Law Project.

*Public housing programs help in Pennsylvania*

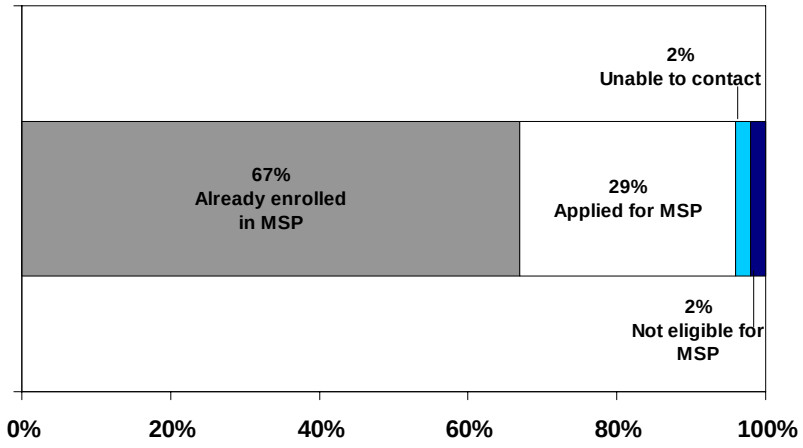
The State Solutions grantee in Pennsylvania also worked with public housing sites to identify potential enrollees. After trying a number of approaches to reach and assist residents, the Pennsylvania Health Law Project developed the "100% Pledge" program, an effort to screen all public housing residents at specific housing sites, with the assistance of two property management companies. The Pennsylvania Health Law Project trained service coordinators from the companies on the eligibility criteria of Medicare Savings Programs and served as a back-up legal resource for questions. The management companies committed to screening residents for MSP eligibility during annual rent re-certifications. Either the service coordinators or staff from the Pennsylvania Health Law Program assisted residents who appeared to be eligible for MSP with the application process.

Data from one of the management companies indicate that during the first seven months of "100% Pledge," some 307 residents were screened for MSP eligibility at housing sites. Of these, nearly all qualified financially, but the majority already were enrolled in the Medicare Savings Programs (see Figure 10).

**Figure 10**

**Results of 2004-2005 Screening for the Medicare Savings Programs at Public Housing Sites in Pennsylvania**

(Number screened = 307)

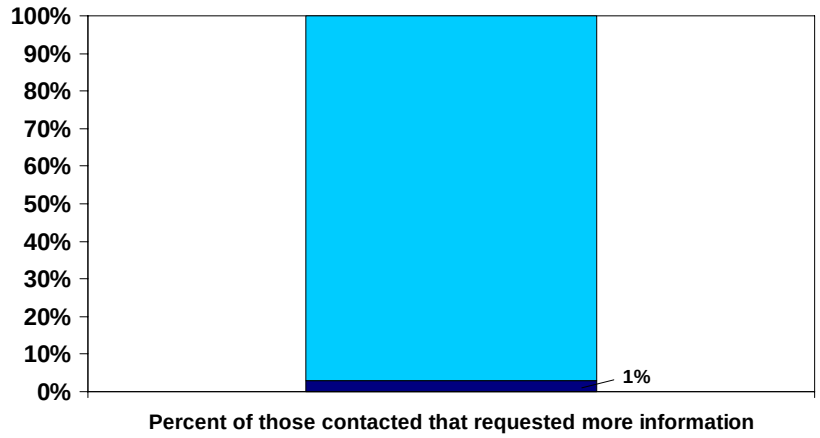



Source: Georgetown University Health Policy Institute calculations based on data from the Pennsylvania Health Law Project.

*Meals-on-Wheels participants learn about the Medicare Savings Programs in Pennsylvania*

In Pennsylvania, flyers with information on MSP were also distributed in five regions to "Meals-on-Wheels" recipients. In one region, a three-page flyer was distributed; in all the other regions, a one-page flyer was used. Flyers were distributed once in one region, and multiple times in the other regions. Overall, flyers were distributed to 9,819 individuals, and 94 people called PHLP in response to the flyers (see Figure 11). The first region, where flyers were distributed 40 times to 100 individuals, had the highest response rate, 15 percent. Response rates in other regions ranged from 0.5 to 4 percent.

Figure 11
**Response to 2003 "Meals on Wheels" Flyer Distribution in Pennsylvania**
(Potential participants contacted = 9,819)




Source: Georgetown University Health Policy Institute calculations based on data from the Pennsylvania Health Law Project.

**Conducting outreach and enrollment activities with community leaders**

State Solutions grantees have worked with community-based groups to promote the Medicare Savings Programs, to identify community residents who may be eligible for but unaware of the programs, and to provide assistance with enrollment.

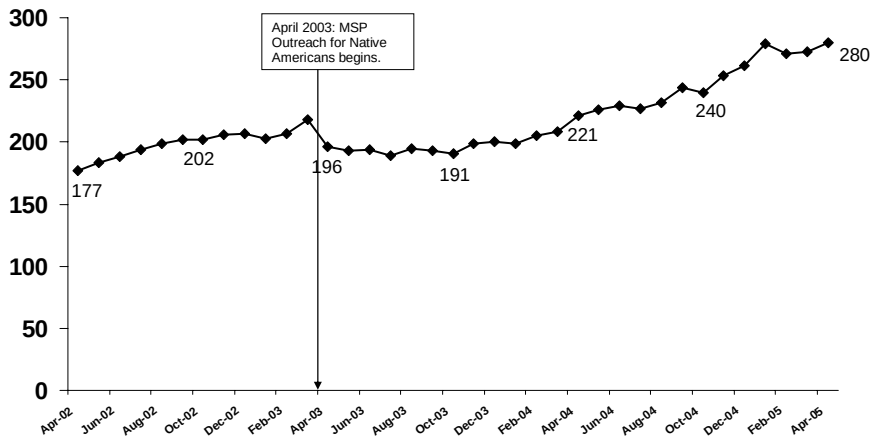
*State Senators in Pennsylvania send outreach letters to constituents*

The Pennsylvania Health Law Project educated state senators about the Medicare Savings Programs. Several recognized that the programs would benefit their constituents and three volunteered to send outreach letters encouraging constituents to apply. The proportions of constituents requesting program applications as a result of the mailings ranged from less than one percent to five percent of those who received letters.

*American Indian Elders representatives participate in MSP outreach activities in Minnesota*

Minnesota has a made an effort to reach out to its Native American population. The state conducted trainings for 51 volunteers who already work with the *Senior LinkAge Line*, the State Health Insurance Assistance Program, in regions where reservations are located. The volunteers were paired with Indian Health Service workers. The program started in April 2003. Two years later, Native American enrollment in the Medicare Savings programs had increased by 43 percent (see Figure 12).

**Figure 12**
**Native Americans Enrolled in the Medicare Savings Programs in Minnesota**




Source: Georgetown University Health Policy Institute calculations based on data from the Minnesota Department of Human Services

*Community-based "deputies" help with MSP enrollment in New York*

New York permits the "deputization" of community-based organizations to conduct the face-to-face interview required for enrollment in MSP. The Medicare Rights Center, the State Solutions grantee in New York, was the first deputized group and it provides training to other groups.
Participating groups include senior centers, disability groups, and organizations that have the capacity to work with different ethnic groups or with individuals whose first language is not English. Currently there are more than 200 deputized sites, but relatively few MSP applications are being submitted through deputized groups. Between February 2003 and February 2005, the number of applications submitted monthly from deputized organizations in New York City ranged from seven to 40. The low numbers of applications from other deputies may be an indication that the groups would like to participate in the "deputization" project, but do not have the time or resources to commit to actively encouraging members of the communities they serve to apply.[3]

**Lessons from activities to identify, reach, and enroll potential program participants**

Based on tracking calls for information, requests for help, applications sent to potential participants, applications returned, and individuals enrolled in the Medicare Savings programs, it appears that the use of program data to identify and facilitate the enrollment of potential MSP beneficiaries can be particularly effective. This and other lessons from the State Solutions project are presented below.

- *The use of program data to identify and facilitate the enrollment of potential MSP beneficiaries can be particularly effective*, as activities in Minnesota and Pennsylvania show.

- *Generally, the effectiveness of mass mailings is limited*, with very small proportions of beneficiaries responding to numerous mailings in State Solutions states.

- *If mass mailings are used, the data on which they are based should be as specific as possible with regard to eligibility criteria*. Pennsylvania's direct mail project to entire zip codes did get some response, but the rate was not as high as the response in which mailings were sent to PACE and PACENET participants who appeared to meet specific eligibility requirements. Mailings sent to smaller, better identified populations are also likely to be more cost-effective than broad mass mailings.

- *To be most effective at eliciting a response, mass mailings should be tailored, with specific information about who to contact locally and how to apply for benefits*. Data from Louisiana show, for example, that mailings from the Social Security Administration were much more successful when letter recipients were given specific telephone numbers to call for more information.

- *Attention-getting formats appear to work*. Minnesota's effort to make their letters to prospective MSP enrollees stand out by using neon stickers elicited a relatively large response.

- *Frequency of communication may also be helpful in gaining attention*. For example, the only region where a substantial number of Meals-on-Wheels participants responded to an information flyer distributed in Pennsylvania was the region in which the flyer was distributed 40 times, suggesting that the repeated distribution of information was important. Even in that region, however, the response rate was only 15 percent (compared to four percent or less in other regions). These results suggest that even with repetition, distributing flyers may not be a cost-effective outreach approach.

- *It is important to determine the extent to which the target population is already enrolled in a program before committing substantial resources to outreach*. The Pennsylvania Health Law Project, for example, invested considerable time and resources in working with public housing sites, but the data show that about two-thirds of the residents screened for MPS eligibility already were participating in the program.

- *People respond to trusted information sources*. Experience in New York shows that community organizations have the potential to substantially increase enrollment by targeting information and services to specific populations. They have limited time and resources to put toward outreach, however, and so efforts to engage community leaders should include specific training, ongoing encouragement, and, if possible, resources.

### *Activities geared to changing policy*

Activities to identify and reach potential program participants are an important part of efforts to increase enrollment in the Medicare Savings Programs, but they are not sufficient to guarantee enrollment increases. Even if people are aware of and in need of program benefits they may not complete the application process if it is too onerous. Also, enrollment will be negatively affected if eligible program participants do not renew their benefits successfully and on time because the renewal process poses problems. Some policy changes have the potential to simplify the enrollment and renewal process and therefore, to increase program participation significantly. For example, eliminating requirements for verification documents, lengthening eligibility periods, amending rules related to estate recovery, making changes to the process used to pay Medicare Part A premiums for some individuals can play a role in increasing program enrollment.

**Policies related to asset tests**

Asset tests are a barrier to participation in the Medicare Savings Programs for some low-income Medicare beneficiaries.[4] Federal rules set income and asset limits for the Medicare Savings Programs, but states have some discretion with regard to the methods used to count income and assets and the process used to make eligibility determinations for the programs.[5] Many have taken steps to develop simple application and renewal processes for the Medicare Savings Programs, though there is still considerable difference in procedures across states.

Among the actions that states have taken:

- Some states disregard – or do not count – particular assets, or disregard some part of the value of assets when eligibility is determined so that asset limits for the programs are effectively higher than the federal standard.[6]
- Some states allow applicants to make "self-declarations" about the value of their income or assets. They are not required to provide verification documents.
- Most states allow individuals to submit applications by mail rather than having to appear for a face-to-face interview.
- Most states have taken steps to simplify the application form for the Medicare Savings Programs.
- Some states have streamlined the renewal process so that program participants are not required to reapply for benefits, but are simply asked to indicate that their financial circumstances have not changed significantly and therefore they remain eligible.

Four states – Alabama, Arizona, Delaware, and Mississippi – have eliminated the asset test for all Medicare Savings Programs.[7] A number of other states still have asset tests, but have made changes in rules for counting assets.

*Policy changes regarding asset tests in Louisiana*

In September 2003, Louisiana changed its policy regarding asset limits and rules for verifying the value of assets. Under the old policy, the value of life insurance or burial funds exceeding $1,500 was counted in determining the total value of an applicant's assets. Applicants were required to provide documents to verify the values. Under the new policy, the allowable deduction for the value of life insurance or burial funds is $10,000 and applicants are only required to provide verification documents if the value of either of these assets exceeds $10,000. The new process is easier for applicants who often have difficulty obtaining copies of life insurance policies or related documents. The change also has had a positive impact on Medicaid analysts' jobs.

As part of the State Solutions project, Louisiana participated in a study that evaluated the administrative costs associated with its enrollment and renewal processes. Structured interviews were conducted with Office Coordinators and Medicaid Analysts in six parishes in five regions of the state. Every Medicaid Analyst indicated that the new policy has had an impact on his or her work, accounting for a reduction, on average, of 21 minutes during the enrollment process and 19 minutes during the renewal process. In addition, fewer verification forms are sent so the cost of printing and postage has been reduced. On an annual basis, the savings that accrue from this policy change is almost $1.7 million.[8]

*New York eliminates the asset test for the QI program*

In April 2002, New York eliminated the asset test for QI applicants. In the first part of 2002, monthly enrollment increases ranged from two to five percent, but from mid-2002 to mid-2003, QI enrollment

increased from nine to eleven percent. Subsequent increases were smaller, but QI enrollment continued to grow.

**Policies related to the renewal process**

Changes to simplify renewal procedures can also affect enrollment in a positive way and can promote administrative savings. There is evidence to show that the financial circumstances of older people with low incomes do not change substantially over time.[9] If information already has been verified at enrollment, a repeat of the verification process may be unnecessarily time-consuming and costly.

*Louisiana uses a simple "ex parte" process at renewal*

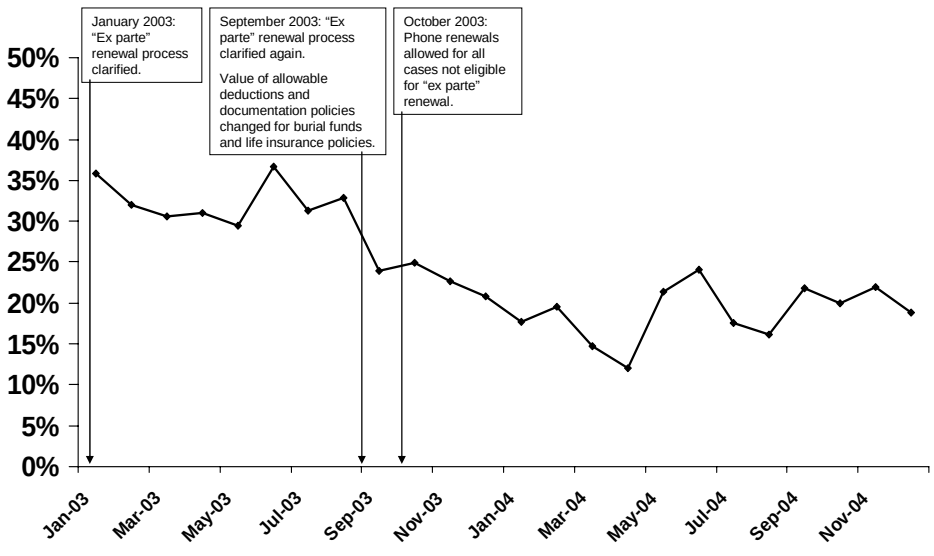
Louisiana tracks MSP renewal rates and the reasons that benefits are not renewed. The two top reasons for benefits not being renewed are procedural reasons: the beneficiary's failure to return the renewal form or to provide appropriate verification of income or assets.

In light of these findings, Louisiana made an effort to streamline the renewal process so that the process requires very little on the part of MSP beneficiaries. Under the new system, Medicaid Analysts attempt to conduct "ex parte" renewals, by searching databases for other programs, such as Food Stamps, to verify that individuals still meet income and asset requirements for MSP. If no further information is needed from a beneficiary, the Analyst updates the computer system, changes the date of eligibility, and sends a notice to the beneficiary that enrollment has been extended for another year.

This policy was first introduced in 2001, but later review by state officials found that the "ex parte" renewal procedures were not implemented across the state. Clarification of the policy was issued in January 2003 and September 2003. In October 2003, state policy changed again to allow phone renewals for MSP beneficiaries who were not eligible for "ex parte." If the "ex parte" review is not possible, or if the review indicates that a beneficiary may not longer be eligible for benefits, the Medicaid Analyst calls the beneficiary to ask for additional information. If the information cannot be obtained by telephone, a renewal application is sent with a postage-paid envelope to the beneficiary.

Early in 2003, over seven percent of MSP cases were closed at renewal, but the proportion declined to about four-and-a-half percent in early 2005. At the same time, the proportion of case closures for procedural reasons was less than half as great as it had been (see Figure 13).

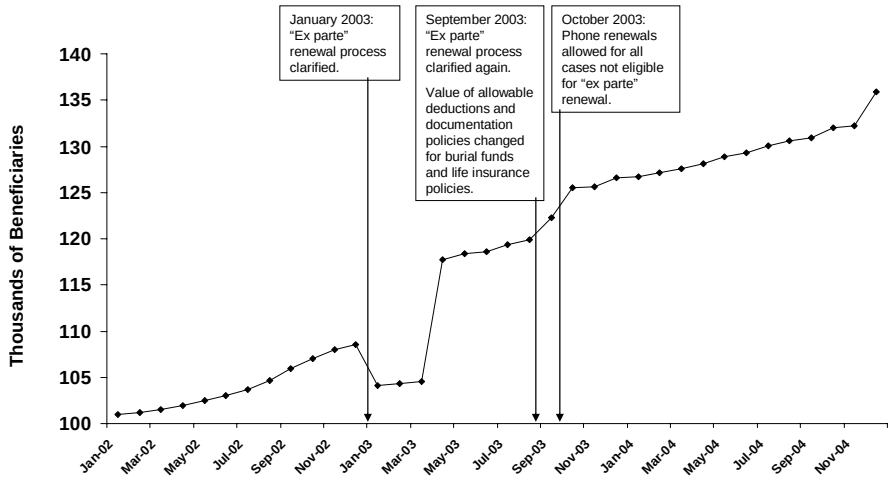
**Figure 13**
**Procedural Closures of MSP Cases at Renewal in Louisiana**




Source: Georgetown University Health Policy Institute calculations based on data from the Louisiana Department of Health and Hospitals.

An examination of MSP enrollment figures for Louisiana over time shows the positive cumulative effect of policy changes related to MSP enrollment and renewal (see Figure 14).

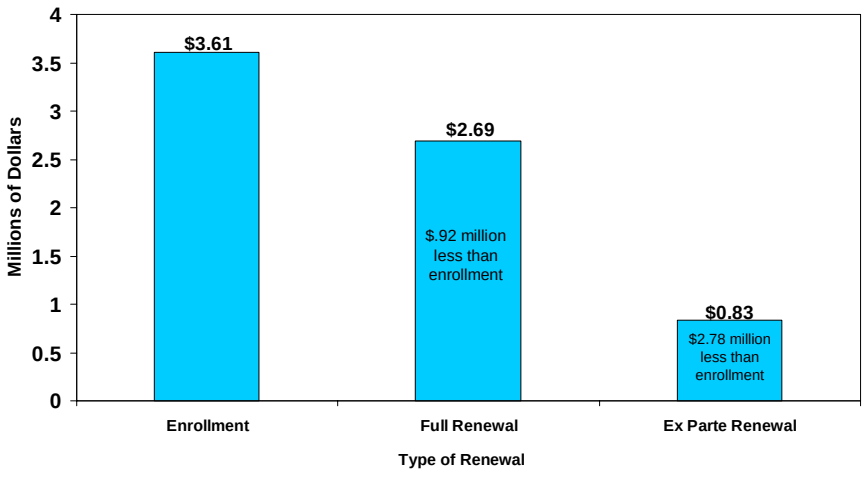
**Figure 14**
**Medicare Savings Program Enrollment in Louisiana**




Source: Georgetown University Health Policy Institute calculations based on data from the Louisiana Department of Health and Hospitals.

In addition to making the recertification process simpler for MSP beneficiaries, the "ex parte" renewal process saves the state money. Almost 85,000 program participants renewed coverage for the Medicare Savings Programs in Louisiana in the 12-month period beginning June 2003. Data from the State Solutions administrative cost study show that if the renewal process had been the same as the initial enrollment process (as it is in some states and had been in Louisiana before simplification) the basic renewal costs for the states would have been over $3 million. The use of the simpler renewal process can save more than $1.5 million on an annual basis and if the "ex parte" renewal process were used universally, the savings would be about $2.4 million annually (see Figure 15).[10]

Figure 15
**Annual Administrative Costs and Savings Associated with Different Types of Renewal in Louisiana in 2003**




Source: Georgetown University Health Policy Institute calculations based on data from the Louisiana Department of Health and Hospitals.

**Policies related to verification documents**

State Medicaid offices generally ask applicants to provide documents to verify the value of their income or assets or to show proof of age or citizenship. In fact, the only requirement imposed by federal law regarding documentation for Medicaid is that states verify immigration status for applicants who are not U.S. citizens or nationals.[11] Requirements to produce documents can pose a barrier to enrollment.[12] Thus, some states have changed rules related to verification to make the application and renewal processes simpler for applicants and eligibility workers. As noted earlier, Louisiana changed the policy regarding the verification of assets in the fall of 2003. Several other states have made changes as well.

*Minnesota does not require asset verification for most MSP applicants*

In Minnesota, assets are only verified if they are within $300 of the limit.[13] A State Solutions study of the administrative costs associated with the enrollment and renewal processes for Minnesota's Medicare Savings Programs shows that changes in rules for verifying assets – which occurred in 1998 – have produced administrative savings. On average, financial workers report that, per enrollee, they spend nine minutes less at enrollment and ten minutes less at renewal verifying information related to assets since the implementation of the rule. Given the volume of applications and renewals processed annually, this time savings represents a savings of over $800,000. Printing and postage costs also have been reduced because of a decreased need to send requests for information related to the value of assets and to return documents submitted for verification purposes.[14]

*New York changes requirements for some MSP applicants*

In New York, requirements to provide verification documents for assets were eliminated for the SLMB program in April 2002. Although SLMB enrollment increased somewhat, the policy change does not appear to have had a significant impact on enrollment. Self-declaration of assets for all community-based Medicaid applicants was allowed in New York beginning in August 2004.

*New Hampshire changes some rules related to verification*

A study conducted for the State Solutions project, of administrative costs associated with enrollment and renewal for MSP benefits in New Hampshire, demonstrates that the verification process is time consuming and therefore, costly. When Family Support Specialists in New Hampshire were asked to describe the most common problems or questions that applicants have, the overwhelming response was that applicants have difficulty providing the information or documents that are needed to verify information about financial status, particularly information about the value of assets. Similarly, Family Support Specialists report that for them, the most difficult and time-consuming part of the enrollment process is verifying information about income or assets. On average, about two-thirds of the time they spend verifying financial information is spent on asset verification. Requirements for applicants to provide documents showing the value of their assets are meant to ensure that the value of assets is reported accurately, but data from New Hampshire suggest that this may not be the most efficient or effective system. Family Support Specialists estimate, for example, that it takes an average of nine minutes each time they have to verify information about the value of life insurance policies, yet they also report that only about two percent of MSP applicants are found ineligible because of discrepancies in reporting the value of the asset (see Table 2).

Responses from Family Support Specialists in New Hampshire indicate that they spend about 13 minutes, on average, verifying information about life insurance and burial plots. This includes the time they spend sending reminders or forms to verify information. With the number of people applying for and renewing

benefits, these activities cost almost $69,000 annually. If the limits for which verification is required were increased or if self-declaration were allowed with regard to life insurance and burial plots, administrative spending could be reduced considerably.

***Table 2: Time spent verifying asset values and outcomes of the verification***

| Asset | Average time spent to verify information provided (minutes) | Proportion of MSP applicants found ineligible because of discrepancies in reporting the value of the asset |
|---|---|---|
| Bank Accounts | 4 | 4% |
| Life Insurance Policies | 9 | 2% |
| Burial Funds | 4 | 1% |

Source: Georgetown University Health Policy Institute based on data from the Community Services Council of New Hampshire.

**Policies related to the certification period**

Recertification for the Medicare Savings Programs is required at least annually to ensure that program participants are still eligible to receive benefits. Most states conduct recertification activities for the Medicare Savings Programs every twelve months.[15]

*Minnesota has short certification periods*

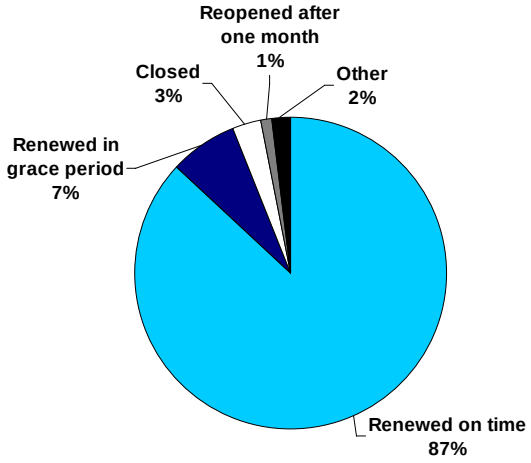
Minnesota requires that recertification occur every six months rather than annually for MSP beneficiaries who have fluctuating income. Data analyzed for the State Solutions project indicate, however, that very few individuals enrolled in the Medicare Savings Programs lose coverage at the six-month renewal. Over a 12-month period beginning in April 2004, for example, only one percent of the cases due for renewal were closed monthly, on average. The vast majority – 87 percent – were renewed with no interruption. An additional seven percent were processed within the one-month grace period, and three percent of enrollees re-enrolled after a short gap in coverage (see Figure 16).

**Figure 16**

**Renewal Outcomes for the Minnesota Medicare Savings Programs**

Monthly Average, April 2004 to March 2005

(Cases up for renewal = 11,823)



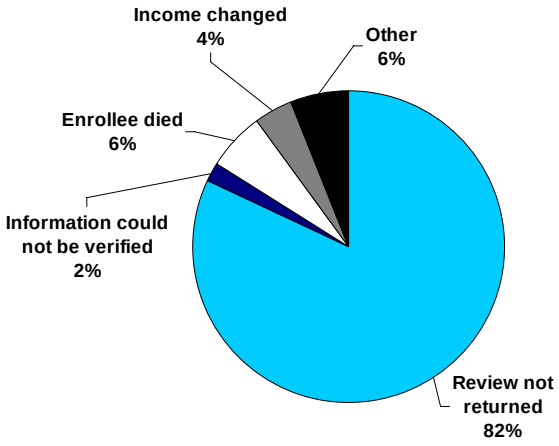

Source: Georgetown University Health Policy Institute calculations based on data from the Minnesota Department of Human Services

The state also tracks the reasons for MSP case closures. The most common reason for case closures among the MSP population is that eligibility review forms are not returned. Many of those who fail to return the forms initially submit them later and are determined eligible for continued coverage. Death was the reason for the next largest category of closures. Only six percent of cases closed – representing 15 individuals or approximately .001 percent of the total cases due for renewal in a 12-month period – were closed for reasons related to changes in income (see Figure 17).

**Figure 17**

**Reasons for Case Closures at Renewal in the Minnesota Medicare Savings Programs**

Monthly Average, April 2004 to March 2005




Source: Georgetown University Health Policy Institute calculations based on data from the Minnesota Department of Human Services

Data from the study of administrative costs in Minnesota also show that less frequent renewals would generate significant administrative savings. Some 167,030 eligibility reviews for the Medicare Savings Programs were conducted in Minnesota in 2004. At a cost of $36.35 per review, the total cost is almost $6.1 million. If recertification occurred annually instead of every six months for all beneficiaries, millions of dollars could be saved annually.[16]

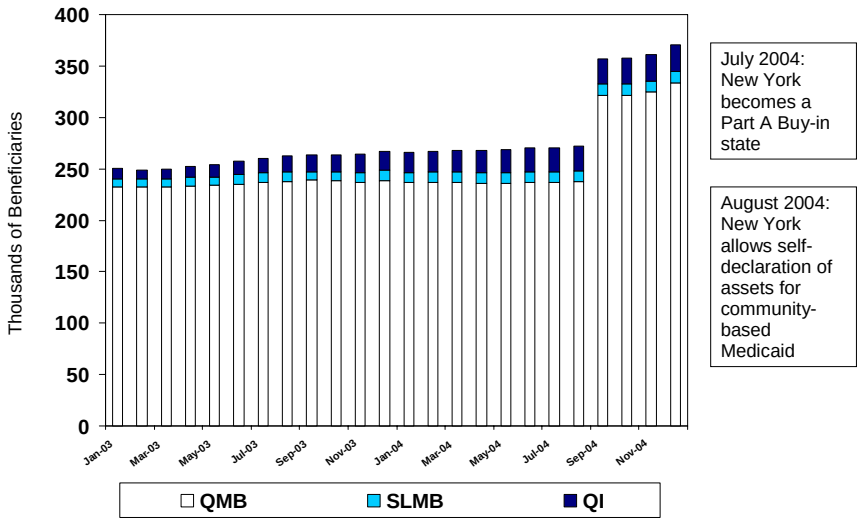
**Policies related to the Part A Buy-In**

Most individuals who are eligible for Medicare Part B also are eligible for Part A coverage and do not have to pay premiums for Part A. Some individuals who are eligible for Part B have not worked long enough to qualify for premium-free Part A. If those individuals meet the income and resource requirements of the QMB program, states may purchase Part A coverage on their behalf. States can purchase Part A coverage in two ways, as a "Part A Group Payer State" or as a "Part A Buy-In State." When states use the first method, individuals must go to the Social Security office to conditionally enroll in Part A and then go to the local Medicaid office to apply for the Medicaid program to pay their Part A premium. Individuals are required to complete this process during the general enrollment period (January 1 to March 31 of each year); if they do not, the state is required to pay a 10 percent surcharge on the Part A premium. When the second method is used, individuals are not required to conditionally enroll at the Social Security office. Instead, the state examines Medicaid program records to identify those individuals who appear to meet the criteria for the Part A buy-in program. These individuals are then enrolled in the QMB program and they receive premium-free Part A benefits.

*New York to changes the Part A buy-in policy*

In July 2004, New York State, which had been a "Part A Group Payer State" became a "Part A Buy-in State." The policy was adopted after the state Office of Medicaid Management estimated that the program would have a net savings of $75 million annually in local and state funds because providers of Medicaid services would then be required to bill Medicare for claims that previously had been paid by Medicaid and because the state would no longer be required to pay a 10 percent surcharge for individuals enrolling outside of the general enrollment period.[17] Enrollment in the MSP increased sharply after New York became a Part A Buy-in State. Between August and September 2004, for example, QMB enrollment increased 30 percent (see Figure 18).

Figure 18
**Medicare Savings Program Enrollment in New York**




Source: Georgetown University Health Policy Institute calculations based on data from the Medicare Rights Center.

**Policies related to estate recovery**

Some individuals are reluctant to apply for Medicare Savings Programs because they have concerns about Medicaid estate recovery policies. Federal Medicaid rules require that states recover payments from the estates of deceased Medicaid beneficiaries who have received nursing facility services. States are not required to recover payments for other services, but are authorized to do so. As of 1999, about half of the states reported that they did not have an estate recovery requirement for the Medicare Savings Programs.[18] Still many people are wary of applying to Medicaid for any service because they have heard about estate recovery.

*Estate recovery policy changes in New Hampshire and New York*

Based on recommendations made by the New Hampshire Legal Assistance and Medicare Savings Plan Workgroup, New Hampshire's Department of Health and Human Services made a change in the Medicaid policy to eliminate estate recovery for QMB and SLMB beneficiaries. The Workgroup was able to show that the existing estate recovery policies were a deterrent to enrollment and the amount of money recovered had been very small. New York also eliminated estate recovery for the Medicare Savings Programs in April 2002.

**Lessons from activities geared to changing policy**

Experience from State Solutions grantees' efforts to change MSP policy are presented below.

- *Certain policy changes regarding the methods for counting and documenting asset values appear to have a positive impact on enrollment*. This was demonstrated in Louisiana and New York.

- *Policies to simplify the renewal process promote enrollment* by reducing the number of beneficiaries who lose benefits at renewal for procedural reasons such as failure to return forms or to provide documents.

- *Policy changes to simplify the enrollment and renewal processes can also achieve some administrative program savings* as illustrated in Louisiana, Minnesota, and New Hampshire.

- *Annual rather than more frequent renewal requirements can have a positive impact on enrollment and achieve administrative savings.*

- *Changes in state purchasing policies related to Medicare Part A premiums can increase MSP enrollment*, and, as demonstrated in New York, can promote savings for the state.

- *The routine collection and use of data regarding not only program enrollment, but also application and renewal outcomes, is very helpful in showing whether efforts to increase enrollment have been successful and in demonstrating whether certain policy changes would be helpful*. For example, Louisiana's Department of Health and Hospitals and Minnesota's Department of Human Services report regularly on the proportion of MSP case closures for procedural reasons and on the specific reasons for closure

.

## *Efforts to understand and improve the outcomes of activities to increase enrollment*

Several of the State Solutions grantees examined outreach activities in order to make improvements if necessary. Specifically, several attempted to track applications submitted as a result of outreach activities. Also, some grantees held focus groups to elicit opinions about effective outreach techniques and Louisiana conducted a consumer satisfaction survey.

**Tracking applications from outreach events or activities**

The ability to track where an application originates and whether it is processed successfully is a potentially useful tool to evaluate the effectiveness of activities to increase enrollment.

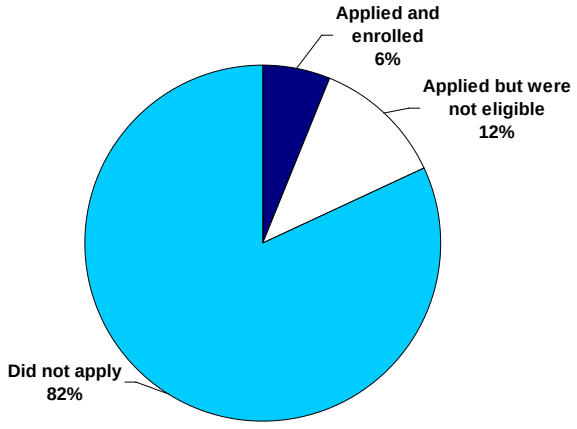
*Louisiana tracked participation for outreach efforts*

As part of the State Solutions project, Louisiana's regional Medicaid offices used a tracking system for outreach events they held. The offices were asked to mark applications distributed at particular events and to report on the number of applications distributed, completed at the outreach event, and returned later. They also were asked to track the number of applications certified and rejected. Of the 315 applications distributed at eight events and tracked, about 18 percent were completed and returned; about one-third of applicants qualified for MSP (see Figure 19).

**Figure 19**

**Response to 2002-2003 Outreach Events in Louisiana**

(Potential participants receiving applications = 315)




Source: Georgetown University Health Policy Institute calculations based on data from the Louisiana Department of Health and Hospitals.

*Pennsylvania developed a coding system for applications*

The Pennsylvania State Solutions grantee attempted to implement a statewide system to code applications to show where the applicant had obtained the form or received help in completing or submitting it. Problems with this system arose, however, because workers did not enter the codes from the applications consistently. Therefore the grantee was unable to determine which application sources were used most frequently.

*New Hampshire color-coded applications*

The Community Services Council of New Hampshire, the State Solutions grantee in New Hampshire, used peach-colored forms for MSP applications submitted through HICEAS, the state health insurance

assistance program. Thus, Medicaid program officials became aware of the volume of applications submitted with the help of HICEAS. They also noted that the error rate for the "peach applications" was very low.

**Interviewing program participants and potential participants**

Focus groups and surveys helped State Solutions grantees plan outreach activities, design program applications, and address difficulties related to enrollment, particularly for certain populations.

*Focus groups for people with disabilities were held in Louisiana*

Louisiana conducted focus groups to learn more about how to reach and enroll persons with disabilities. Four focus groups were held in nine Medicaid regions, with a total of 45 participants, 32 of whom were currently receiving MSP benefits. Participants were asked to comment on the utility of MSP program applications, the application process, barriers to enrollment, and methods to reach other potential MSP beneficiaries.

Focus group participants generally agreed that the application process was simple and straightforward, stating that the information required was not difficult to furnish, and that they were pleased by the length of the form. There is some confusion about the meanings of the terms "assets" and "resources," and there was a lack of understanding regarding the information requested about burial and life insurance questions on the application.

Lack of awareness about the Medicare Savings Programs was identified as a major barrier to participation. The focus group participants revealed that potential beneficiaries learn about MSP through a wide variety of sources, including doctors' offices, outreach events, Social Security offices, assistance programs, and from family, friends, and individuals that participate in MSP. Participants most strongly recommended televised public service announcements to raise awareness of MSP. They also suggested radio and newspaper advertisements, direct mail, outreach at Section 8 and public housing, and more outreach at senior events, senior citizen centers, and partnerships with faith-based initiatives. Participants said that partnering with state and federal agencies and training staff in other agencies so that they would be aware of how MSP could benefit their clients would also help boost awareness and participation, and several participants recommended directing outreach efforts toward mental health offices.

Another barrier to MSP participation is the perception that the state agency is difficult to navigate, particularly because of the poor attitudes displayed by staff members. Although most of the comments were related to problems with the Food Stamp Office, respondents were also hesitant to deal with the Medicaid office. Perceptions of MSP as a government handout or charity program also prevents some people from seeking out more information and applying.

*Focus groups for seniors were held in Minnesota*

Minnesota conducted six focus groups and one individual interview, reaching 63 seniors. Focus group questions centered on news sources favored by seniors, seniors' recommendations for the best ways to promote the Medicare Savings Programs, and sources for assistance with matters related to Medicare.

Local television was the predominant news source identified by many, and others said that national and state television news programs are also important. Some reported radio and local newspapers as key news sources, especially the Star Tribune. Several also mentioned the importance of Spanish language television and radio.

Many participants get their information about programs such as MSP through word of mouth, and recommended senior centers as the best way to promote the program. They also advised that newspapers, newsletters, and flyers would get information out to seniors, and some recommended educational forums.

Family members are an important resource for many seniors who have questions or concerns about programs. Many also depend on their physicians, and some said they would go to their insurance companies with questions. For questions about Medicare, seniors indicated that they would call the 1-800 Medicare number or ask their physicians. One-to-one assistance programs also were cited as being useful, both in-person and over the phone, making the application process much easier. Participants said that they would recommend people contact the county for more information on programs.

*Louisiana studied the needs of homebound individuals*

In 2005, Louisiana conducted a study of the needs of homebound individuals, interviewing 95 individuals, 52 of whom were MSP beneficiaries to learn how to improve the application and enrollment processes for this population. The respondents, most of whom are no long ambulatory due to accidents and illnesses, reported that they their main sources of information about health care and benefits are people who regularly come to their homes including home health attendants, Councils on Aging representatives who provide Meals-on-Wheels and Homemaker Services, family, friends, and neighbors, as well as their physicians. They cited lack of knowledge about where to obtain reliable information as a barrier to program participation. There was consensus that many people in Louisiana do not know about the program or understand its benefits. The majority of those who were not MSP beneficiaries said they had not heard of the program until they were contacted for the study. Participants suggested recruiting new participants by advertising through the media and educating community partners and physicians about the program. Other suggestions for increasing enrollment were to eliminate or increase the resource limit so more people with low incomes could qualify. Also, respondents said it is important to tell people that there is no cost to participate in the Medicare Savings Programs.

Those who participated in the Medicare Savings programs reported favorable opinions of the program. Many noted that they appreciated the simplicity of the application process and thought that handling so

much of it by mail or telephone was very helpful for those who do not have reliable transportation or help from family or friends.

**Lessons from efforts to understand and improve outreach outcomes**

Two important lessons emerged from State Solutions grantees' efforts to understand and improve outreach outcomes.

- *Direct feedback from current and potential beneficiaries is an important first step in planning outreach efforts*.

- *The effectiveness of methods to track responses to outreach activities may be limited by coding problems*. Grantees in Louisiana, New Hampshire, and Pennsylvania, established systems to measure the impact of certain activities, but encountered difficulties because the data either were not coded at all or the coding was inconsistent. All noted that more training and ongoing monitoring is required and that the individuals in the field who are asked to code applications or collect data in other ways are more likely to be responsive if they have a good understanding of the purpose of the data collection.

## *Conclusion*

Enrollment increased in the Medicare Savings Programs in all five states participating in the State Solutions project over the three-year period of the project. Many factors contributed to the increases, but efforts on the part of the five grantees likely played an important role. The grantees led efforts to identify and enroll MSP participants and to change program policies to facilitate enrollment. Outcome data suggest that outreach efforts were most successful when they were carefully targeted to individuals who meet the program eligibility criteria and when they included specific information about how and where to get help. Efforts to understand the application process from the beneficiaries' perspective also helped grantees develop strategies to improve program operations. A range of policy changes, which resulted in simpler application and renewal processes, also were helpful in boosting enrollment. The need to reach and enroll low-income Medicare beneficiaries in the Medicare Savings Programs as well as in the Medicare Part D low-income subsidy program persists. Lessons from the State Solutions project are relevant as state programs and other organizations in states strive to ensure that low-income beneficiaries receive the benefits they need.

**Acknowledgements**

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## *Endnotes*

[1] U.S. General Accounting Office. 2004. " Medicare Savings Programs. Results of Social Security Administration's 2002 outreach to low-income beneficiaries," Washington, DC.
[2] Blume, Randall. March 2004. "Linking State Prescription Programs with Medicare Savings Programs: Examples from New Jersey and Minnesota," Rutgers Center for State Health Policy. Available at: www.statesolutions.rutgers.edu.
[3] In addition to the community based organizations that serve as deputies, some health care providers also have case workers onsite who serve as deputies. But, while MRC collects MSP applications from all other deputies to submit to Medicaid, these providers submit the applications they approve to Medicaid themselves, so their numbers are not tracked.
[4] See, for example, Summer, Laura and Lee Thompson. May 2004. "How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits," The Commonwealth Fund, New York; Rice, Thomas and Katherine Desmond. 2005. "Low-income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test," Kaiser Family Foundation, Washington, DC.
[5] Federal rules specify that various MSP benefits be available to people with incomes less than 135 percent of the federal poverty level and with countable assets valued at less than $4,000 for an individual and $6,000 for a couple. Under section 1902(r)(2) of the Social Security Act, however, states have the ability to use less restrictive methods for calculating the value of income or assets than those specified in federal law.
[6] Certain deductions are allowed in making calculations for the value of assets. For example, federal law allows a deduction for the value of an applicant's home. Federal law also specifies deductions for the value of certain assets, such as automobiles, that applicants can own.
[7] Centers for Medicare & Medicaid Services. 2005. "Medicare Savings Program (MSP) Eligibility Criteria." Available at: http//:new.cms.hhs.gov/States/Downloads/MSPEligibilityCriteriaChart.pdf.
[8] Summer, Laura. 2004. "Administrative Costs Associated with Enrollment and Renewal for the Medicare Savings Programs: A Case Study of Practices in Louisiana," Rutgers Center for State Health Policy. Available at: www.statesolutions.rutgers.edu.
[9] Summer, Laura and Lee Thompson, "How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits," The Commonwealth Fund, May 2004.
[10] Summer, Laura. 2004. "Administrative Costs Associated with Enrollment and Renewal for the Medicare Savings Programs: A Case Study of Practices in Louisiana," Rutgers Center for State Health Policy. Available at: www.statesolutions.rutgers.edu.
[11] A provision in the Deficit Reduction Act of 2005 requires that, beginning July 1, 2006, all new Medicaid applicants and all current Medicaid enrollees who renew their eligibility must produce proof of citizenship.
[12] See for example, Perry, MJ, Kannel, S. and Dulio, A. 2002. "Barriers to Medicaid enrollment of low-income seniors: Focus group findings." Kaiser Commission on Medicaid and the Uninsured, Washington, DC; Summer, L. and Ihara, E. 2005. "Simplifying Enrollment in Medicaid and Medicare Savings Programs for the Elderly and Individuals with Disabilities," AARP Public Policy Institute, Washington, DC.
[13] Asset limits for the Medicare Savings Program in Minnesota are $10,000 for individuals and $18,000 for couples, substantially higher than the limits set by federal law – $4,000 for individuals and $6,000 for couples.

[14] Summer, Laura. forthcoming. "Administrative Costs Associated with Enrollment and Renewal for the Medicare Savings Programs: A Case Study of Practices in Minnesota," Rutgers Center for State Health Policy.
[15] Summer, L. and Ihara, E. 2005. "Simplifying Enrollment in Medicaid and Medicare Savings Programs for the Elderly and Individuals with Disabilities," AARP Public Policy Institute, Washington, DC.
[16] Summer, Laura. forthcoming. "Administrative Costs Associated with Enrollment and Renewal for the Medicare Savings Programs: A Case Study of Practices in Minnesota," Rutgers Center for State Health Policy.
[17] Memorandum, New York Office of Medicaid Management, Division of Consumer and Local District Relations, July, 2004.
[18] Nemore, Patricia. 1999. "Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries: A 1999 Update." The Henry J. Kaiser Family Foundation, Washington, DC.

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.

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