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Improving Access to Health Care in a Changing Landscape: Facilitating Enrollment in Medicare Savings Programs and Medicare Part D

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Summary of the State Solutions Spring Summit
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Executive Summary

The new federal Medicare Part D benefit and Low-Income Subsidies (LIS) or "extra help" will offer many low-income beneficiaries valuable assistance with paying for prescription medications. Many of these beneficiaries may also be eligible for the underenrolled Medicare Savings Programs (MSPs), which provide financial assistance with Part B premiums and other costs. Since 2001, The Robert Wood Johnson Foundation and The Commonwealth Fund have supported an initiative known as "State Solutions" to improve MSP enrollment. In May 2005, the State Solutions National Program Office (NPO), at Rutgers Center for State Health Policy, convened a two day invitational summit to discuss opportunities and challenges to increasing enrollment in MSPs with the roll-out of the Medicare Part D. State and federal policymakers, private sector leaders, researchers, and advocates identified potential strategies to integrate and simplify enrollment in MSPs and LIS, to raise awareness in the private sector and other state programs that serve similar populations, and to discuss ways for states to coordinate and maximize MSP enrollment with the implementation of Part D. The following paper summarizes the key findings of the summit and areas for continued work.

Major Points

- Several changes to federal statute related to Part D and Title XIX of the Social Security Act could help to facilitate enrollment into LIS and MSP programs and integrate these two programs. These changes should be kept in mind as future long term solutions, after the implementation and operation of Part D are underway.

- The Centers for Medicare & Medicaid Services (CMS) could pursue several options that would increase MSP enrollment. These include autoenrollment of LIS eligibles into MSPs in states with more liberal eligibility criteria and approving state plan amendments that would liberalize MSP eligibility criteria.

- The Social Security Administration (SSA) could increase MSP enrollment by screening and enrolling in MSPs at the time of LIS application, sharing improved leads data with states that would include verified income and asset information, and integrating MSP outreach with LIS outreach.

- Integrating the model Federal MSP application with the LIS application could reduce the number of steps necessary for individuals to apply for both programs.

- States could be required to screen and enroll individuals based on leads data they receive from SSA. This would be facilitated if SSA provided states with its verified income and asset information.

- State Medicaid programs could reduce the burden of administering the MSP programs by eliminating or liberalizing the asset test or easing documentation requirements. States that have done so have realized substantial savings.

- State Pharmacy Assistance Programs (SPAPs), which currently assist low-income individuals with prescription drug costs, could also realize substantial savings by ensuring that their eligible beneficiaries enroll in LIS and MSPs.

- The private sector will play a major role in administering Part D and may have incentives to enroll their members into MSPs. This avenue could be further explored with Part D plans and Special Needs Plans after the initial implementation and operation stages of Part D have begun.

- Participants identified two key areas in which the State Solutions NPO would play a valuable role: sharing outreach and education "best practices," and guidance on sharing data between state-federal and state-state programs in light of legislation/regulations concerning privacy issues.

- Finally, participants emphasized the importance of continuing dialogue among federal, state, private sector, researchers, and advocates to develop strategies for maximizing MSP enrollment.

Introduction

The Medicare Prescription Drug, Modernization, and Improvement Act of 2003 (MMA) created a new prescription benefit that provides valuable "extra help" to low-income beneficiaries. Many of these beneficiaries may also be eligible for Medicare Savings Programs (MSPs), which pay for low-income Medicare beneficiaries' Part B premiums and other costs. The MSPs have historically been underenrolled despite a number of public and private initiatives to increase enrollment. The roll-out of Medicare Part D offers a unique opportunity to simultaneously help low-income Medicare beneficiaries get extra help for both Part D and Part B costs, but only if the two programs are coordinated.

Since 2001, The Robert Wood Johnson Foundation and The Commonwealth Fund have supported an initiative known as "State Solutions" to improve MSP enrollment. In May 2005, the State Solutions National Program Office (NPO), at Rutgers Center for State Health Policy, convened a two day invitational summit to discuss opportunities and challenges to increasing enrollment in MSPs with the roll-out of Medicare Part D. CSHP convened state and federal policymakers, as well as leaders in the private sector, research and advocacy communities to identify ways to increase MSP enrollment with the rollout of Part D. The goals of the meeting were:

- To discuss the interaction between the Medicare Part D low-income subsidies (LIS) or "extra help" and MSPs, and how enrollment and retention in both programs can be increased;
- To identify specific policy changes that could be made at the federal and/or state levels in the short and long-term to integrate, encourage and simplify enrollment in MSPs and LIS, including those that had been successfully implemented by State Solutions grantees over the past three years;
- To raise awareness in the private sector and other state programs that serve similar populations about the MSPs and why it is in their interest to maximize enrollment; and
- To discuss operational issues of what states can do now to coordinate and maximize MSP enrollment with Part D implementation.

The meeting was one in a series of activities that the State Solutions NPO will undertake in the upcoming year to encourage MSP enrollment beyond its grantee states to the nation at large. The Summit explored topics related to expanding MSP enrollment in the "New World" of Part D, challenges faced by states, expanding SSA's role in identifying and enrolling MSP eligibles, administrative simplification, building partnerships with the private sector, and lessons learned from the Medicare discount card experience. The following is a summary of the key findings, specifically focusing on opportunities and policy options identified for each stakeholder group to assist in increasing MSP enrollment through the implementation of the new Part D benefit.

Policy Options to Promote Enrollment in Medicare Savings Programs

Changes to Federal Statute

Speakers throughout the meeting identified potential changes to either the MMA statute or Title XIX of the Social Security Act that would help to facilitate enrollment into the LIS and/or MSP programs and to integrate these two benefits that are targeted to similar populations. Many acknowledged that statutory changes were unlikely to occur prior to the implementation of Part D, and were longer-term solutions that should be pursued in the future when amendments to the MMA are likely to be considered. Potential statutory changes include:

- Eliminating the LIS and MSP asset test which presents a barrier to enrollment in both programs and increases administrative costs;
- Modifying federal minimum MSP criteria to be the same as LIS eligibility;
- Requiring SSA to do MSP screening and enrollment, and provide additional appropriations for this function;
- Federalizing the MSP program - options include:
  - Federally fund and administer the entire MSP program,
  - Increase Federal match rate for MSP enrollees,
  - Provide Federal financial participation (FFP) bonuses to states with higher enrollment rates, and
  - Increase FFP for outreach activities; and
- Modifying laws to allow SSA to share LIS eligibility data with states.

Shorter-term Federal Procedural/Administrative Changes

Short of passing legislation, speakers at the meeting identified several opportunities to increase MSP enrollment under the current rules through administrative changes that could be made either by CMS or SSA under their scope of responsibilities for Part D implementation.

Autoenrolling LIS Enrollees into MSPs in States with More Liberal Eligibility Criteria

One barrier identified in integrating MSP and LIS enrollment is the differences in eligibility criteria between the two programs. The LIS eligibility is based on the federal standard defined in the MMA. In contrast, eligibility criteria for the MSPs are set by the states with approval of their state plans by CMS.[1] In general, the LIS eligibility criteria are more generous than MSP minimum federal eligibility standards, which present a barrier for simply autoenrolling all LIS eligible persons into the MSPs. Some speakers suggested modifying the federal MSP eligibility standards to mirror the LIS which would require statutory change and could face opposition by the states.

[1] While states must meet a minimal federal standard, they can modify or disregard specific sources of income or assets from eligibility, thereby liberalizing income and asset eligibility requirements. See Table for minimum federal requirements for MSP programs.

Short of passing legislation, there may be an opportunity for CMS to at least autoenroll LIS eligible persons into MSPs in those states that have liberalized MSP income and asset disregards or eliminated the asset test altogether. In these states, the MSP eligibility criteria may be comparable or even more liberal than the federal LIS eligibility criteria; meaning that if an individual were eligible for LIS, he/she would also be eligible for MSP. In these states, enrollment in MSPs could be increased if the state's LIS enrollees were automatically enrolled into MSPs. This would require that states share with CMS their MSP rolls so that CMS may know which LIS eligibles are not in MSPs. CMS could then share this information with states to autoenroll people into MSPs.

In her remarks, Gale Arden from CMS indicated that the CMS Administrator had already requested his staff to conduct an examination of state plan language to determine which states have MSP eligibility criteria that are the same or more liberal than the LIS criteria. Because states determine their own MSP eligibility rules, it is not always clear whether states have more generous rules than LIS. Ms Arden indicated that CMS will share its findings with the states and work with states with more generous eligibility rules to define a process for autoenrolling LIS enrollees into MSPs.

Since the summit, CMS has completed its analysis and the findings are available at http://www.cms.hhs.gov/medicarereform/states/msp_charts.pdf. Based on this analysis, CMS concludes that only five states (Alabama, Arizona, Delaware, Minnesota, and Mississippi) have more generous MSP eligibility criteria than the LIS and could be eligible for autoenrollment. The State Solutions NPO will continue to follow-up with CMS on these developments and keep other states apprised of any progress in this area.

Table: Comparison of LIS and Minimum Federal MSP Eligibility Criteria*

	LIS		MSPs		
Program	**Full LIS**	**Partial LIS**	**QMB**	**SLMB**	**QI-1**
Income limit	< 135% of FPL	≥ 135% and < 150% of FPL	≤ 100% of FPL	> 100% and ≤ 120% of FPL	> 120% and ≤ 135% of FPL
Resource limit (single/couple)	$6,000/ $9,000	$10,000/ $20,000	$4,000/ $6,000	$4,000/ $6,000	$4,000/ $6,000

* Individual states may have more generous QMB, SLMB, and/or QI-1 criteria.

Requiring SSA to Screen and Enroll in MSPs

One approach to increase SSA's role in promoting MSP enrollment is requiring SSA to perform MSP eligibility determinations. Patricia Nemore from the Center for Medicare Advocacy argued that this may not require statutory change. Currently SSA performs Supplemental Security Income (SSI) determinations for eleven to twenty states through agreements with individual states and SSA would be a logical place for MSP screening, especially since SSA will already be making LIS determinations. Several speakers indicated that requiring SSA to perform MSP eligibility determinations would potentially increase MSP enrollment; removing the welfare stigma attached to applying for the MSPs at a Medicaid office, and eliminating one additional step for applicants. As they are applying for the LIS, they can also apply for the MSPs, and they would be submitting similar information for both programs at the same time.

Beatrice Disman from SSA indicated that granting SSA the authority to screen for MSPs would require statutory change and additional appropriations to carry out these functions. She indicated that, although SSA does make SSI determinations in some states, there is an administrative fee that the states pay which is adjusted yearly. Many states have been dissatisfied with the level of payment required for SSA to make these determinations on their behalf.

An alternative idea proposed to increase SSA's involvement in MSP enrollment is allowing states or advocates to station their outreach workers in regional SSA offices to perform MSP screening. New Hampshire noted that, prior to September 11, 2001, State Health Information Assistance Programs (SHIP) workers were allowed to do MSP outreach and determinations in SSA offices. However, after 9/11, volunteers were no longer allowed in federal offices in her region due to security concerns. By allowing outreach workers to do MSP screening in SSA offices, applicants would not have to go to their state Medicaid offices for screening and more potentially MSP eligible individuals could be reached. As this was discussed at the end of the second day, SSA was not available for comment. The State Solutions NPO is investigating current rules regarding the presence of volunteers in SSA offices and is discussing the feasibility of this model with SSA and CMS.

Requiring States to Use LIS Leads Data

Under Section 1935(a)(3) of the Social Security Act, states are required to "screen and enroll" LIS applicants into the MSPs.[2] While this statutory requirement has largely been interpreted as only being required for individuals who present at a state Medicaid office to apply for the LIS, it also could be

[2] CMS. Federal Register, Vol. 70 No. 18, January 28, 2005, p. 4419.

interpreted as being required for individuals for whom SSA sends leads data to the state. During the summit, questions arose as to what specific responsibilities the "screen and enroll" obligation would entail and how states were to deal with leads data received from SSA. For states that set Medicaid eligibility at 100 percent of Federal Poverty Level (FPL), an individual enrolled in the Qualified Medicare Beneficiary (QMB) program would also qualify for full Medicaid benefits. Such states may be concerned about the "woodworking" effect of this requirement, especially given their current fiscal difficulties. Also, states may have reached their cap for enrollment in their Qualifying Individual program (QI-1), in which case they would not be able to offer enrollment to LIS applicants. Ms. Arden indicated at the Summit that guidance to states was forthcoming. Since the Summit, CMS has released guidance that addresses some states' concerns and takes a more narrow definition than many advocates had suggested of states' responsibility to follow up on leads data. CMS does not require that states follow up on leads data but only "strongly encourages states to do so."[3]

Providing Specific Asset and Income Info on Leads Data or Sharing LIS Worksheets

SSA will be collecting income and asset information from LIS applicants, which it will electronically verify through various databases. Based on this information, SSA sends data to CMS which will then send states leads data about individuals who may also qualify for the MSPs. According to CMS and SSA representatives, the leads data from SSA will include the approval or denial decision, income and asset ranges, but not actual income, asset, or household composition information. In order for states to follow up on the leads data provided by SSA, states will have to contact applicants, re-collect this data from the applicants, and verify the data they collect. Typically states do not have the capacity to electronically verify data as SSA does, so there is more time and administrative effort required of states. However, one way to save applicants the hassle of applying twice and save states the administrative burden of determining and verifying eligibility is by providing SSA's verified information directly to the states. This could be achieved by either:

- Providing complete verified information on the leads data to states,
- Allowing applicants to consent to SSA sharing their information directly with states for the purpose of MSP screening, and
- Allowing applicants to bring a copy of the SSA worksheet, which has their verified (or unverified) information on it, to the state for MSP screening.

Jim Carey from SSA stated that the reason SSA is not allowed to share complete income and asset information on the leads data is because some states' information systems are not equipped to receive all

[3] CMS. Guidance to States on the Low-Income Subsidy, May 25, 2005, Section 20.1. http://www.cms.hhs.gov/medicarereform/guidance5-25-05.pdf.

of SSA's information and also SSA has very specific restrictions on who can see the data, which in some cases, excludes states. Mr. Carey also raised the issue that some states may have different verification requirements and may not accept SSA's verification process. However, SSA said they are looking into the possibility of building consent language into the LIS application, which if signed, would allow SSA to disclose verified information with states. SSA is currently discussing whether this consent could be included in the 2007 LIS application form since the application for 2006 has already been finalized. Ms. Disman also invited feedback from states that might be interested in piloting the consent process on a local basis, before committing to a nationwide effort.

Approving State Plan Amendments that Liberalize MSP Criteria in One or All Programs

States may be interested in modifying their eligibility criteria for selected MSP programs. Their reasons may vary from trying to increase enrollment in the MSPs (and therefore increase enrollment in the LIS for additional SPAP savings), increasing benefits to their MSP populations (e.g. offering full Medicaid benefits to QMB enrollees), or aligning MSP with LIS criteria. Although CMS has approved state plan amendments that liberalized MSP eligibility criteria in one or all MSP programs in the past, summit participants were fearful that CMS might be less likely to approve them going forward.

Based on subsequent discussions with CMS, they will continue to review and approve state plan amendments as in the past that may include liberalizing eligibility criteria in the MSP programs. CMS clarified, however, that current rules do require that if eligibility rules are changed for higher income persons, the rules must also be changed for lower income persons. Therefore, proposals to liberalize criteria in the QI-1 program would need to extend the same criteria to SLMBs and QMBs. However, if states elect to liberalize criteria in their lower income QMB program, they do not need to extend those same criteria to SLMB or QI-1.[4]

Integrating Model Federal MSP Application with LIS Application

The Government Performance and Results Act of 1993 (GPRA) identified a lengthy, complex application form as a barrier to applying for the MSPs. In response to this barrier, Ms. Arden indicated that CMS designed a model streamlined application for MSPs, which it estimates has been used by approximately 80 percent of states. A number of these states have adapted or modified this model based on their state's requirements. Since the LIS and MSP populations overlap, rather than having two separate applications, CMS could move to integrate the two applications into one uniform model application similar to the one developed for MSPs. In response, Ms. Arden indicated that developing a uniform application for both

[4] Personal communication with Gale Arden on July 22, 2005.

programs would be a good long-term goal for states and CMS to pursue. The State Solutions NPO will continue to work with CMS in moving toward a uniform application.

Integrating LIS and MSP Message in Outreach/Education Efforts

Section 1144 of the Social Security Act requires that SSA identify individuals eligible for MSPs and notify these individuals and their state that they may be eligible. Several evaluations have been performed looking at the effectiveness of SSA's MSP outreach. Separate findings of the Lewin Group and the Government Accounting Office of SSA's mailings in 1999, 2000, and 2002 showed that the mailings increased individuals' awareness about the MSPs and also enrollment in MSPs. The Lewin Group found that letters were a very effective outreach method, much more so than other forms of media such as radio announcements or posters. Also, SSA is considered by the elderly as a trusted source of information. Given the success of SSA's 1144 mailings and the overlap in the MSP and LIS populations, enrollment rates in MSPs would be further increased if SSA's LIS letters included mention of possible eligibility for other extra help, which could help Medicare beneficiaries pay for their Part A and B cost-sharing as well as help with Part D. SSA could send this additional information in its letters informing individuals that they may qualify for LIS, in its LIS application approval/denial letters, and other LIS related correspondence. Since states have different MSP eligibility criteria, SSA's LIS mailings could simply tell people they may be eligible for assistance with paying for Medicare expenses and to contact their state for specific program descriptions. Ms. Disman replied that an MSP notice will be included on the LIS award/denial letter.

Since the Summit, SSA has released sample Notice of Award and Notice of Denial letters which will be sent to LIS applicants. Although the letters mention that applicants may be able to get more help through MSPs; they do not mention that individuals who are determined ineligible for the LIS can actually be deemed eligible for LIS if they enroll in an MSP in their state; this would be the case for individuals living in states with more liberal MSP eligibility criteria than LIS eligibility criteria. This may be an incentive for people to make the additional effort of applying at their state Medicaid office for the MSPs. The following is an excerpt from the sample Notice of Award and Notice of Denial letters.

> ***Information About Medicare Savings Programs***
> *You may be able to get more help with your Medicare health care costs through programs run by your State. The additional help from these Medicare Savings Programs can be worth more than $900 a year. To get this help, please call your State's medical assistance (Medicaid) office or your social service office and ask about the Medicare Savings Programs. You can get the local phone number for these offices by calling*

Medicare toll-free at 1-800-MEDICARE (1-800-633-4227). If you are deaf or hard of hearing, you may call the Medicare TTY number toll-free at 1-877-486-2048.[5]

One suggestion made by Ms. Disman to assist SSA in educating LIS applicants about the MSPs was to have state-specific MSP information available at regional offices. This would consist of a brief description of the MSPs, what they do, who would qualify, what income and asset requirements are involved, and how to apply. Since states determine their own MSP eligibility criteria and what their programs do, this information would have to be specific to the states. SSA could display this one-pager in their waiting rooms and also provide it to their employees to give to LIS applicants. The State Solutions NPO plans to identify state-specific templates from grantee states that might be shared with SSA.

Extending "Deemed" Status to QI-1 Eligibles but Not Enrolled

Officials from New York raised the issue of extending the "deemed" status for the LIS to individuals that were determined QI-1 eligible but were not enrolled because the state had exceeded its cap. Many states, including New York and Louisiana reported that they are nearing their cap of QI-1 enrollees and were concerned that individuals who were denied QI-1 enrollment solely due to submitting their application after the cap was reached, would not be "deemed" eligible for LIS. In states such as Louisiana, this would force enrollees to separately apply for LIS and provide all of the same information to SSA that they had already provided to the state. In states like New York, which has eliminated the asset test in its QI-1 program, many of these individuals would only be eligible for the LIS through the "deemed" status. If they were eligible but not enrolled into the QI-1 program due to the state having reached its cap, they would lose both the QI-1 benefit and the potential to qualify for LIS.

New York asked CMS if it could report its QI-1 eligibles and not only QI-1 enrollees, so that these additional people would also be deemed eligible for LIS. At the summit, Danielle Moon from CMS had indicated that this would not be possible and subsequent guidance issued by CMS after the conference confirms that an applicant must accept MSP enrollment to be deemed eligible for LIS.[6] Another alternative may be to increase the QI-1 cap in states that have reached it or to borrow QI-1 credits from states that have not reached maximum enrollment. Since the Summit, CMS has indicated to the NPO in follow-up conversations that they may modify their policies. In late August, CMS issued a new methodology for calculating State allotments for payment of Part B premiums for QI-1 individuals. Based on figures reported by all states for estimated QI-1 expenditures in Fiscal Year 2005, CMS has

[5] SSA's Program Operations Manual System, Section HI 03094.201 and Section HI 03094.210, 5/24/2005. http://policy.ssa.gov/poms.nsf/aboutpoms.

[6] CMS. Guidance to States on the Low-Income Subsidy, May 25, 2005. Section 20.1.2 specifies that an applicant must accept MSP enrollment to be deemed eligible for LIS. http://www.cms.hhs.gov/medicarereform/guidance5-25-05.pdf.

determined that while some states will reach or exceed their QI-1 cap; most states will have a surplus of QI-1 funds. CMS has reallocated the surplus funds from these states to cover the projected needs of states which are near or at their cap, so that individuals who qualify for QI-1 will not be denied enrollment.[7]

Identified Opportunities for States to Expand MSPs

Many state officials that spoke at the summit indicated that states face two competing objectives in the current fiscal environment – striving to maintain or improve services to constituents versus striving to stay fiscally afloat. Expanding MSPs, although providing valuable benefits to constituents, may further threaten states' already tenuous balance between spending and debt. During the Summit, various approaches were discussed to determine the cost/benefit of expanding MSPs and how states can still expand MSPs in times of budgetary crisis.

Medicaid

State officials from Louisiana and Arizona suggested that reducing administrative barriers to MSP enrollment, such as eliminating or liberalizing asset test requirements or reducing documentation requirements both at initial application and renewal, can not only result in higher MSP enrollment but may actually save the state money as well. Verifying detailed income and asset information requires a considerable amount of staff time and resources. Arizona and Louisiana reported that they have modified their state plan language or made legislative changes to liberalize or eliminate the asset test. Both states reported increased MSP enrollment coupled with significant reductions in administrative costs as a result of simplifying the application process. According to research by Laura Summer, Louisiana saved twenty minutes at the time of application and at the time of renewal because of asset test disregards and ex parte renewal; this was equivalent to at least $1.7 million a year in administrative savings. Additionally, Louisiana has found that ex parte renewal, where the enrollee may be automatically re-enrolled in an MSP without having to repeat the entire application process, has greatly increased its retention rates in MSPs.

One speaker also suggested that potential savings might be achieved through the medically needy programs. Some medically needy individuals, who are also Medicare eligible, may benefit from enrolling in MSPs rather than spending-down to qualify for Medicaid. These individuals would likely be ones who rely primarily on prescription drugs and do not need the other services covered by Medicaid. By enrolling more individuals who currently apply for medically needy help in the MSPs, states could increase the

[7] CMS. Federal Register, Vol 70 No. 165, August 26, 2005, pp. 50214-50220. http://www.cms.hhs.gov/providerupdate/regs/cms2210IFC.pdf.

number of individuals who would be deemed eligible for the LIS. These individuals would thus gain valuable assistance with paying for their Medicare Part A/B premiums, deductibles, and copayments; accessing prescription drugs; and would be less likely to spenddown to full Medicaid. In the past, clients and outreach workers for the Medically Needy have had limited experience with MSPs, but this may be a new source of drug coverage that would suit the needs of some medically needy individuals. Also, by shifting this group to federal Medicare coverage, states would be relieved in part of additional spending on Medicaid.

State Pharmacy Assistance Programs (SPAPs)

States that have SPAPs may have an economic incentive to identify an MSP eligible but not enrolled person within their existing SPAP. Once enrolled into the MSPs these members would be deemed eligible for the LIS, thereby relieving states of the additional administrative costs of ensuring that their enrollees apply for the LIS.

Identifying SPAP enrollees currently eligible but not enrolled in MSPs will require matching SPAP and Medicaid enrollment files. New York's SPAP reported that their program had encountered difficulties in the past trying to exchange data with Medicaid; however, they were hopeful that Part D would make data sharing between the two programs easier. Massachusetts' SPAP reported that they were aware of a significant number of SPAP enrollees who are eligible for MSPs or Medicaid, but that they had not reached out to them because of budget concerns. Currently about 12,000 of their members are enrolled in MSPs, with another 20,000 who are at least income-eligible for MSPs.

Additionally, if the state liberalized MSP eligibility criteria by eliminating asset tests, even more SPAP enrollees could be "deemed" eligible for the LIS than would be eligible if they just applied directly to SSA. Since the LIS represents a substantial federal benefit that would offset current state SPAP expenditures, increasing the number of LIS eligibles in SPAPs through MSP eligibility expansions could result in net savings to the state. States may want to perform cost-benefit analyses for expanding MSP eligibility. For states that have QMB-plus or SLMB-plus programs, which have expanded full Medicaid benefits to these individuals, the additional Medicaid costs would not be offset by SPAP savings from additional enrollees being LIS eligible. However, states that only provide Medicare Part B premium or cost-sharing assistance may discover that the savings to the SPAP outweigh the costs to Medicaid.

Some states with less generous SPAP benefits did raise a concern that the more generous LIS benefits coupled with MSP eligibility expansions could have a "woodwork" effect, encouraging people who

previously did not sign up for the SPAP or MSPs, to now enroll. This concern varied by state. Louisiana and Maine did not project large increases in MSP enrollment in their budgets because their programs had either already liberalized MSP eligibility or had done extensive outreach. In contrast, as mentioned above, Massachusetts is concerned that they would face large increases in costs if MSP enrollment was increased and therefore they have not done much outreach within their SPAP.

Identified Opportunities for Partnering with the Private Sector to Expand MSPs

The federal government has designed the Part D drug benefit to be a privately-run initiative. The role of the private sector has previously been important in Medicare managed care and now will be even more pronounced. As such, the federal government and states will need to coordinate with the private sector. Ideas were discussed at the Summit to promote the interactions between states and the private sector in the implementation and operation of Part D, and how to engage these new private partners in maximizing MSP enrollment.

Part D Plans and Special Needs Plans

Once the initial implementation and operation phases of Part D are fully underway, several speakers from the industry and the research community suggested that Part D plans may be interested in identifying and enrolling their members into MSPs. As partial duals, MSP enrollees are likely to have a higher risk adjustment, meaning more federal dollars to offset plan costs. However, Medicare Advantage Prescription Drug Plans (MA-PDs) and Special Needs Plans (SNPs) may have a greater interest than PDPs in the MSP population because of additional cost-sharing for other services that MA and SNP plans cover. Also, given that MSP beneficiaries are more frequently enrolled in Medicare managed care than Medicaid beneficiaries, MA-PDs and SNPs are likely to see larger numbers of MSP beneficiaries than PDPs. Plans are also forming relationships with other partners who may have incentives to enroll people in MSPs. Federally qualified health centers and hospital networks are interested in enrolling people in MSPs in order to reduce “bad debt” generated by uninsured patients. These groups may be interested in partnering with MA-PDs and SNPs to identify MSP eligibles.

States are a valuable potential source of information for SNPs as they are being designed. SNPs will serve mainly duals, and states have historical information on drug use and expenditure for this population. However, even though SNPs will serve duals, they are not required to work with states, which will continue to provide Medicaid services for this group after the prescription benefit is implemented. States have expressed interest in collaborating with SNPs but since CMS will not be making plan awards until September 2005, states may not have adequate time to work with SNPs.

Identified Areas for Continued Work

During the Townhall Discussion, grantee states expressed an interest in continuing communications with the NPO beyond the State Solutions grant cycle. This could involve the NPO sending follow-up email alerts on issues raised during the Summit and sending NPO alerts which include links to SHIP Weekly Digests, CMS Enrollment Reports, Dear Marci newsletters,[8] and other related items.

States requested a clear and concise state-level description of MSPs that could be shared with legislators and regional SSA offices. The descriptions should be short and concise with a maximum of ten bullets that describe what MSPs are, what they do for people, and the long-term impacts of MSPs to people and states.

States were interested in sharing ideas about outreach/education activities and materials for MSP, LIS, and Part D. Some states, particularly State Solutions grantee states, have developed effective outreach activities and materials for MSPs, which could be shared with other states through the State Solutions NPO. Also, with the vast influx of new information on Part D and the LIS, and trying to maintain outreach efforts on MSPs; participants stressed the importance of providing clear, concise messages written at an appropriate reading level.

States were interested in learning how to tackle privacy issues surrounding data sharing between SSA and states and between state programs to identify clients. States are often confused about what is and is not allowed, in part because there is no clear cut definition of the HIPAA regulations and because the law itself is subject to interpretation. States were interested in working with SSA to obtain more descriptive leads data that would include income and asset information.

In addition, states would like to find out how some states have successfully managed data sharing across programs from a technical standpoint, e.g. information systems requirements and the possibilities, challenges, and costs involved in automating eligibility. Another data issue raised by a participant was how to set up a data collection system up front which would allow tracking of individuals who "fall through the cracks" (i.e. do not get enrolled in MSPs) and the additional costs to states because of their subsequent lack of access to prescription drugs through the LIS. This data collection system could enable states to make more informed decisions about whether or not to pursue increasing MSP enrollment.

[8] A free, weekly newsletter by the Medicare Rights Center, designed to keep social workers, health care providers and other professionals informed about health care benefits, rights and options for older Americans and people with disabilities.

Participants expressed a need for facilitating continued discussions between the private sector, states and advocates to develop strategies for maximizing MSP enrollment, given shared incentives. Since energy is primarily focused on successfully implementing Part D, these discussions might be more fruitful in 2006, after the initial Part D implementation issues are past.

Next Steps – Plans by the National Program Office

The NPO will organize discussions with CMS, SSA and states on the topics brought up during the conference. Since the meeting, the NPO has already followed up with CMS on the evaluation of state plan language, which can be found at http://www.cms.hhs.gov/medicarereform/states/msp_charts.pdf. The NPO is also investigating how to make this information widely available to states to encourage other states considering MSP eligibility expansions. In addition, we will continue to encourage CMS to develop a mechanism for autoenrolling LIS eligible individuals into MSPs in those states determined to have more liberal MSP eligibility criteria than the LIS.

Since the summit, CMS' guidance to states on the "screen and enroll" requirement has also been released and can be found at http://www.cms.hhs.gov/medicarereform/guidance5-25-05.pdf. CMS' decision to encourage but not require states to follow-up on the leads data may require further follow-up. CMS has also issued new regulations on August 26, 2005 that reallocate federal funding for the QI-1 program so that states that had would have exceeded their cap for FY 2005 will not have to deny enrollment in the program. The NPO may also wish to identify "best practices" of using leads data for states that intend to use this new data source, as well as work with CMS and SSA on the new generation of leads data and how it can be improved. As CMS has indicated in subsequent conversations to the summit, they are still open to state amendments that modify MSP eligibility methodologies so long as they extend the same methodologies to lower income groups. The NPO may work with grantee or other states to assess the cost/benefit of pursuing this course.

The NPO will follow-up with SSA on issues stemming from the conference. The topics will include how SSA will coordinate the 1144 mailings and the LIS letters, the possibility of incorporating a consent into the LIS application, the possibility of providing LIS applicants with a worksheet containing their verified information that could be brought to State Medicaid offices for MSP determination (SSA is issuing worksheets with their decisions already),[9] compiling state-specific MSP descriptions for SSA regional offices, and the possibility of stationing SHIP outreach workers in regional SSA offices to perform MSP

[9] Written communication with Beatrice Disman on September 8, 2005.

determinations. The NPO will also set up conference calls between individual states and SSA as necessary to continue these discussions.

The NPO will continue to communicate with grantee states and states that attended the Summit about issues that were raised during the Summit and other MSP-related topics. The NPO will also compile and share ideas on outreach efforts and materials for Part D and the MSPs that have been developed and used by states, and is writing an issue brief looking at case studies of three states' plans for coordinating their MSP enrollment activities with the Part D roll-out. Finally, the NPO will continue to release other issue briefs on various topics including HIPAA privacy issues and more stringent state rules, technical issues surrounding data sharing, and models for outstationing workers at SSA offices.

Available Publications

Andersen, Sue L. and William F. Benson. *Medicare Savings Programs Outreach in Housing for Elders.* Andersen Benson Consulting Services, LLC, September 2004.

Blume, Randall. *Linking State Prescription Programs with Medicare Savings Programs: Examples from New Jersey and Minnesota.* Blume Associates, LLC, March 2004.

Fox, Kimberley and Jasmine Sia. *Maximizing Medicare Savings Program Enrollment through Medicare Part D*. Rutgers Center for State Health Policy, May 2005.

Patterson, Sally. *Conducting Focus Groups for Individuals with Disabilities*. Radiant Communications, April 14, 2004.

Summer, Laura. *Administrative Costs Associated with Enrollment and Renewal for the Medicare Savings Programs: A Case Study of Practices in Louisiana.* Health Policy Institute, Georgetown University, August 2004.

Tiedemann, Amy M. and Kimberley Fox. *Promising Strategies for Medicare Savings Program Enrollment: Modifying Eligibility Criteria and Documentation Requirements*. Rutgers Center for State Health Policy, December 2004.