Local Promise:

Maximizing Enrollment into Low-Income Medicare Programs through State-Based Consumer Advocacy

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Scott Dershowitz

520 Eighth Avenue, North Wing, 3rd Floor
New York, NY 10018
212.869.3850

1224 M Street NW, Suite 100
Washington, DC 20005
202.637.0961

www.medicarerights.org | www.medicareinteractive.org

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Executive Summary

This paper examines several collaborative advocacy efforts in New York, Maine, Kansas, and Florida to increase enrollment in the Medicare Savings Programs (MSPs, which help people with Medicare and low incomes afford medical care), through eligibility expansion and improvements to enrollment and recertification processes. The report also explores opportunities for future reforms in the four states and nationwide, particularly through implementation of recently passed legislation, including the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, which in turn can inform implementation of the Patient Protection and Affordable Care Act (PPACA) of 2010. Opportunities include expanding MSP eligibility and promoting additional eligibility and administrative reforms at the local, state, and federal levels, increasing cooperation between state agencies and policymakers and consumer advocates, and improving communication among state and federal agencies.

The states examined in this paper face a variety of on-the-ground challenges, common to many if not all states, that necessitate creative solutions to ensure maximum enrollment in public benefits among the Medicare population. Additionally, all states are facing fiscal hardship—with budget deficits and damaging cuts to social services a pervasive reality—and responses to these crises vary. To begin to address many of the challenges posed by current low-income enrollment realities in the four targeted states, as well as new questions posed by MIPPA and PPACA, this report first provides background on low-income Medicare programs—including MSPs, the Part D Low-Income Subsidy (LIS), and State Pharmaceutical Assistance Programs (SPAPs)—and their various interactions. It then describes advocacy efforts, achieved enrollment reforms, ongoing barriers to low-income program enrollment, and MIPPA data transfer plans in New York, Maine, Kansas, and Florida, offering concrete examples of how states struggle with and can persevere over systemic enrollment challenges through consumer education and advocacy efforts.

As an example of what is possible, consider that New York, Maine and Florida, working within financial constraints, have in recent years expanded eligibility, revamped enrollment processes, and/or streamlined enrollment practices for older residents. Florida overhauled its enrollment systems and identified cost-saving measures such as an online application process. Maine and New York—offering an especially promising series of practices to other states intent on increasing the enrollment of older adults and people with disabilities in public benefits— eliminated the asset test for Medicare Savings Programs, making it easier for people with Medicare not only to enroll in these benefits but also to access the LIS, which has an asset test but in which individuals with MSPs are automatically enrolled regardless of asset levels. Further, Maine and New York have simplified their MSP applications, making it more likely that consumers will complete them accurately and be enrolled in and recertified for benefits in a timely fashion.

Kansas has simultaneously taken strides to educate and reassure its Medicare population about public benefits. An example of this reassurance is the state’s 2003 elimination of the practice of estate recovery for MSP beneficiaries, which had caused many older Kansans to question whether receiving a public benefit might jeopardize their other assets. With the advent of the fiscal crisis, however, Kansas agencies have mandated that the eligibility limits for Medicare Savings Programs not be expanded to cover more low-income older Kansans, fearing that such expansion would put added pressure on the state budget. This paper will address this challenge and consider how older Kansas consumers can nonetheless be assisted in paying for health care.

The national recession and concomitant state budget deficits have created greater need for MSPs among Medicare consumers and their families, and posed new challenges to states trying to meet this need. Consequently, the paper's description of the role of consumer advocacy in pushing for reform and re-engineering of MSP eligibility and enrollment systems is especially relevant at this time. Additionally, MIPPA and PPACA implementation, already underway, provides a seminal opportunity for state-based advocates to ensure that state agencies are leveraging federal programs and funding for their residents with Medicare.

This paper details the work that the Medicare Rights Center has done in New York and started to replicate with local partners in Kansas and Florida to create statewide coalitions of consumer groups to pursue reforms and offer resources to people with Medicare and low incomes. For example, a coalition of groups in New York—the Medicare Savings Coalition—successfully advocated for elimination of the asset test and the face-to-face interview requirement for MSPs in 2008. Now, Kansas Area Agencies on Aging have, with technical assistance from Medicare Rights, formed a Medicare Savings Coalition to bring together advocates and state policymakers to improve education around MSPs and the LIS. Similarly, the Florida Association of Area Agencies on Aging and the University of North Florida are launching their own coalition to address low-income program needs in the state. These coalition efforts can be informed by on-the-ground educational programs to reach consumers, empower them, and channel their experiences into advocacy and implementation work.

While MIPPA and PPACA serve different purposes and offer different benefits to consumers, the successful implementation of each fundamentally depends on effective community engagement and regular communication and coordination among local, state, and federal stakeholders. Through work with consumer advocates and state agencies over the last year in New York, Maine, Kansas, and Florida, Medicare Rights better understands the capacity of state systems to educate older adults about low-income Medicare benefits and enroll eligible individuals in these programs. Lessons learned in the course of this work can inform the implementation of MIPPA and PPACA provisions in the months and years to come. Successful implementation of both pieces of legislation requires that consumers, advocates, state agencies, and federal agencies are committed to coalition-building and frequent communication.

While consumer education ensures that people with Medicare know about and can access low-income supports, particularly in an environment that demands individual initiative, new provisions within MIPPA would greatly simplify the low-income program enrollment process for people with Medicare. MIPPA's data transfer provisions, specifically, mandate that federal data for LIS applicants be transferred to states and used to enroll these same applicants in MSPs. Such a reform would streamline access to the LIS and MSPs, effectively automating the MSP enrollment and recertification process for millions of Americans. Unfortunately, MIPPA's data transfer innovation, launched on January 1, 2010, has not worked in the way that policymakers envisioned, for a variety of reasons. As a result, a valuable opportunity to improve access to benefits nationwide is being lost, unless states can, with federal support, see the opportunities currently available, identify creative eligibility and enrollment solutions, and improve their systems for receiving and processing federal data.

The successful implementation of MIPPA's data transfer provisions would lead to greater enrollment automation at the state and federal level, which could significantly inform the ability of PPACA to coordinate coverage and care for people pre-65 and 65+. Because PPACA's mandate

that most Americans secure health care coverage will require complicated interactions among state insurance exchanges, Medicaid programs, Medicare, and other state assistance programs, it is imperative that solutions be identified now for facilitating communication among often outdated enrollment systems or updating these systems, and that state and federal policymakers work together—informed by consumer advocates—to, where possible, automatically enroll and recertify consumers in needed benefits.

Broad education of consumers and advocates and collective, state-based advocacy are the keys to ensuring that state needs—both at the consumer level and the state systems level—are conveyed to federal policymakers and that the federal government can be sufficiently supportive of state efforts to enroll low-income consumers in public benefits. At the same time, it is important that state-based work is shared federally and among states, to increase the likelihood of replicating promising practices and to avoid unnecessary duplication of effort. This report can serve as a testament to state efforts to increase enrollment in low-income Medicare programs among older consumers and those with disabilities, as well as a model for sharing practices among a variety of stakeholders at local, state, and federal levels.

Introduction

Medicare, the federal health insurance program for people over 65 and those with disabilities, has been the bedrock of health security for the populations it covers. Yet despite this success, Medicare coverage imposes substantial cost-sharing, which, for low-income consumers in particular, can impose barriers to accessing needed health care and prescription drugs. An array of interrelated state and federal programs exists to help low-income people with Medicare afford medical care and medicines, but eligibility restrictions and bureaucratic obstacles prevent substantial numbers of these individuals from obtaining these benefits.

Maximizing the potential of these programs in individual states to realize Medicare's promise of health security for all older adults and people with disabilities requires a unique form of advocacy, one that brings together consumer advocates, social and medical service providers and state officials to focus on both the eligibility criteria and operational details of these low-income assistance programs.

This paper will examine several collaborative advocacy efforts to increase Medicare Savings Program (MSP) enrollment in New York, Maine, Kansas, and Florida, through eligibility expansion and improvements to enrollment and recertification processes. The report also explores opportunities for future reforms in the four states, including increasing cooperation between states and advocates, improving communication between state and federal agencies, and promoting additional eligibility and administrative reforms at the local, state, and federal levels. The lessons learned through implementing these policy reforms and advocacy efforts could serve as useful models for policymakers and advocates as MIPPA and the Patient Protection and Affordable Care Act (PPACA) are implemented over the coming months and years.

Background

Low-Income Assistance for People with Medicare

1. The Medicare Savings Programs

To help ensure access to health care for Medicare consumers with limited incomes, Congress created the MSPs in the 1980s.[1] The three MSPs to be discussed in this paper are the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) programs. All three MSPs pay the monthly premium for Medicare Part B, which covers doctor visits and other outpatient services. QMB also covers coinsurance and deductibles for Medicare Part A- (inpatient care) and Part B-covered services, as well as the Part A premium for individuals without sufficient work history to qualify for premium-free coverage.[2] MSP enrollees, like people with Medicare who receive full Medicaid benefits and those who receive Supplemental Security Income (SSI), are automatically "deemed" eligible for the Low Income Subsidy (LIS) under the Part D drug benefit (described below). People who are deemed for the LIS do not need to apply for it separately or recertify for it, as continued participation in the original benefit to which they applied guarantees continued enrollment in the LIS. People enrolled in MSPs have been shown to have better access to, and make better use of, medical services than people who are eligible for the MSPs but not enrolled.[3]

Table 1. Benefits of MSP Enrollment

	Deeming for LIS	Part B Premium	Part B Coinsurance	Part B Deductible	Elimination of Part B Late Enrollment Penalty	Part A Premium, Co-insurance & Deductible
QI	✓	✓			✓	
SLMB	✓	✓			✓	
QMB	✓	✓	✓	✓	✓	✓

MSPs are administered through state Medicaid programs. QMB and SLMB, which are entitlement programs, are funded through both state and federal dollars. QI, a federal block grant, is 100 percent federally funded. In some states, counties are responsible for administering MSPs, and may pay a small portion of the total cost. Federal law establishes minimum income and asset standards for eligibility, but states have leeway to expand eligibility by employing "disregards," a budgeting method which reduces countable income, for specific amounts or types of income and for some or all assets.

Table 2. MSP Monthly Income Requirements for Medicare Savings Programs, 2010 [4]

	Qualifying Individual		Specified Low-Income Medicare Beneficiary		Qualified Medicare Beneficiary	
	Single	Couple	Single	Couple	Single	Couple
Federal Minimum	$1,219	$1,640	$1,083	$1,457	$903	$1,215
New York	$1,219	$1,640	$1,083	$1,457	$903	$1,215
Maine	$1,670	$2,247	$1,535	$2,065	$1,354	$1,822
Kansas	$1,219	$1,640	$1,083	$1,457	$903	$1,215
Florida	$1,219	$1,640	$1,083	$1,457	$903	$1,215

Income limits, which are based on the Federal Poverty Level (FPL), change yearly. These amounts do not include exclusions for earned income or for the general income disregard, which must be at least $20 per month but may be higher. Other forms of income may be disregarded as well.

Table 3. MSP Asset Requirements for Medicare Savings Programs, 2010 [5]

	Qualifying Individual		Specified Low-Income Medicare Beneficiary		Qualified Medicare Beneficiary	
	Single	Couple	Single	Couple	Single	Couple
Federal Minimum	$6,600	$9,100	$6,600	$9,100	$6,600	$9,100
New York	No Limit	No Limit	No Limit	No Limit	No Limit	No Limit
Maine	No Limit	No Limit	No Limit	No Limit	No Limit	No Limit
Florida	$6,600	$9,100	$6,600	$9,100	$6,600	$9,100
Kansas	$6,600	$9,100	$6,600	$9,100	$6,600	$9,100

National participation rates for QMB and SLMB among eligible elderly consumers have been estimated as low as 33 percent and 13 percent respectively.[6] Low eligibility limits are not the only factors preventing low-income people with Medicare from enrolling in MSPs. An overall lower emphasis on, and knowledge of, MSPs—as compared to food, cash, or other medical programs—by state governments and advocates alike have resulted in lower enrollment rates in MSPs, despite their enormous potential value to people with Medicare.[7] In addition, "bureaucratic disentitlement," inefficient and outdated administrative mechanisms that prevent people who are eligible for a benefit from applying or completing the application process, takes a multitude of forms in different states. Specifically, antiquated public benefit processing systems, burdensome documentation requirements, and lack of application assistance have resulted in an underutilization of MSPs.

2. The Part D Low-Income Drug Subsidy

When Congress created the Medicare Part D prescription drug benefit, it also created the Part D Low-Income Subsidy to help people with limited incomes pay for prescription drugs. The LIS, which is sometimes referred to as "Extra Help," is administered by the Social Security

Administration (SSA), and is fully federally funded. People enrolled in the LIS pay no deductible, low copayments and no premium, so long as their Part D plan's premium is at or below a regional premium benchmark.

Like MSPs, eligibility for the LIS is income- and asset-tested, and the exact figures generally change each year. Eligibility for the LIS does not vary by state, and the application process for the LIS is uniform nationwide. Thus, the counseling messages are also uniform across the country. People can apply for the LIS online at www.ssa.gov, through the mail, by telephone to SSA's 1-800 number, or in person at an SSA field office.[8] States are also required to help individuals apply directly for the LIS.[9]

Table 4. Low-Income Subsidy Eligibility Requirements and Benefits, 2010

	FULL LOW-INCOME SUBSIDY	**PARTIAL LOW-INCOME SUBSIDY**
Income	135 percent of FPL, or $1,218 individual (monthly) $1,639 couples (monthly)	135 to 150 percent of FPL, or $1,218–$1,354 individual (monthly) $1,639–$1,822 couples (monthly
Assets	$8,100 individual $12,910 couples	$12,510 individual $25,010 couples
Benefit	*No monthly premium *No annual deductible *Coverage through the Part D coverage gap *Limited cost-sharing • $2.50 for generics, $6.30 for brand-name, or your plan's standard coinsurance, whichever is cheaper • $0 during catastrophic coverage	*Sliding scale premium *$60 annual deductible *Coverage through the Part D coverage gap *Limited cost-sharing • 15 percent of the cost of the drug • $2.50 for generics, $6.30 for brand-name during catastrophic coverage

Federal law now promotes the screening of all LIS applicants for MSPs. Beginning January 1, 2010, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), requires SSA to send to state Medicaid agencies verified data from adjudicated LIS applications for MSP screening, unless the LIS applicant affirmatively opts out. While states must use the LIS data to start an application for the MSP, they have considerable latitude regarding procedures for processing data. For instance, states may, but are not required to, accept SSA's verification and treat it as a completed MSP application.[10] And states may require additional information from applicants before making an MSP eligibility determination.[11]

Consequently, there is a wide disparity among states' MIPPA work plans. For example, New York, Maine, Massachusetts, and Louisiana all have taken steps to make as many MSP determinations as possible based on the initial LIS data SSA transmits to them. But some states, such as North Carolina and Texas, are following up with consumers to verify the LIS data. In contrast to the states that are automating the MSP application process, Colorado is sending letters to people whose data they have from SSA, and urging them to request an MSP application from their county Department of Health and Human Services.[12]

3. State Pharmaceutical Assistance Programs

Some states offer additional assistance paying for drugs through State Pharmaceutical Assistance Programs (SPAPs). SPAPs provide state-funded prescription coverage for older adults, and sometimes for people with disabilities, and most were established before the passage of the Medicare Modernization Act of 2003 (MMA), which created Part D.[13] When the Medicare Part D program was launched, many states decided to shift their SPAP costs to the federal government by requiring their SPAP members to enroll in a Medicare Part D plan and to apply for the LIS. In these cases, the SPAP became a secondary payer, "wrapping" around Part D, and responsible only for the difference between SPAP copays and the cost-sharing owed under Part D. This strategy has proven to be one of several "Medicare maximization" strategies employed by states to sustain the quality of coverage and care for residents while at the same time reducing state and consumer health expenditures.[14]

Promising Practices to Promote Enrollment in Medicare Savings Programs

Despite their value, participation in the Medicare Savings Programs remains low: by some estimates, just over one-third of eligible people with Medicare are enrolled in the MSPs.[15] In response, advocates and policymakers have identified promising strategies to boost participation in these and other low-income programs. For example, eight states and the District of Columbia have eliminated the asset test altogether.[16] In addition, many states have chosen to increase income disregards to raise state income standards.[17] Other promising strategies include creating a single entry point to apply for and renew multiple public benefits and simplifying application and renewal procedures.

States with SPAPs have a particular incentive to promote greater MSP enrollment, because MSP enrollees automatically qualify for the LIS. Because SPAPs pay secondary to Part D, securing greater LIS participation through MSPs allows the state to shift prescription drug costs to the federal government.[18] Even in states without SPAPs, states may have incentives to relax eligibility standards. For example, eliminating the asset test and simplifying application procedures can help reduce the need for documentation and produce administrative savings for states.[19]

Advocates and nonprofit agencies in some states have formed statewide coalitions focused specifically on streamlining the MSP application process. Groups like the New York State Medicare Savings Coalition, led by the Medicare Rights Center, have developed ways to help more people apply for MSPs, and have educated thousands of social work professionals and Medicare consumers on the benefits of MSPs and the LIS. Through extensive application experience, sharing of best practices, and troubleshooting of MSP denials, the New York State Medicare Savings Coalition and coalitions in other states have successfully lobbied for changes at the state level, and made recommendations to state and federal policymakers on ways to help more people qualify for the LIS and MSPs.

New York

Advocacy Efforts

New York State is home to the New York State Medicare Savings Coalition, which has successfully increased access to the MSP and LIS programs, and could serve as a model for other states seeking

to increase benefit enrollment rates through collective advocacy.[20] The Coalition's primary goal is to involve diverse stakeholders in pursuing reforms that will enable more seniors and people with disabilities to enroll in low-income programs.[21]

The New York State Medicare Savings Coalition, led by the Medicare Rights Center, was one of five state-based projects created in 2002 through the Robert Wood Johnson Foundation's State Solutions Initiative, coordinated by the Rutgers Center for State Health Policy.[22] The New York Coalition is the only one of the original five to survive. The Coalition currently engages more than 75 member organizations from various parts of the state, including community organizations serving people with Medicare, elected officials' offices, and government representatives from the Elderly Pharmaceutical Insurance Coverage program (EPIC, New York's SPAP), the Centers for Medicare & Medicaid Services (CMS) Regional Office, and the New York State Department of Health's (NYSDOH's) Office of Health Insurance Programs (OHIP). The Coalition holds a monthly teleconference to share information and best practices, and to develop advocacy tools.

The Coalition has promoted the Medicare Savings Programs in various ways. For instance, Coalition members developed the New York City Deputization Project, through which the Medicare Rights Center, with support from the Human Resources Administration (HRA), New York City's Department of Social Services (DSS, or Medicaid) office, trains professionals at community-based organizations (CBOs) on how to help their clients complete low-income program applications; since its inception, thousands of new MSP and LIS applications for seniors and people with disabilities have been processed throughout New York City.[23] The Coalition has also advocated for several reforms that New York later implemented, among them elimination of the face-to-face interview requirement for MSPs, and the total elimination of the state's MSP asset test.[24, 25] Further, the Coalition has increased the ability of New York State to maximize federal Medicare funding by advocating that EPIC enroll its eligible members into MSPs, thereby securing for them the federal Low-Income Subsidy. As eligibility has expanded for MSPs in New York, the Coalition has identified new ways to streamline enrollment processes, with a particular emphasis on recertification. For instance, the state could ensure higher levels of recertification through passive renewal, improve data-sharing among government agencies, and adopt automatic enrollment processes for low-income individuals aging into Medicare.[26]

State Reforms

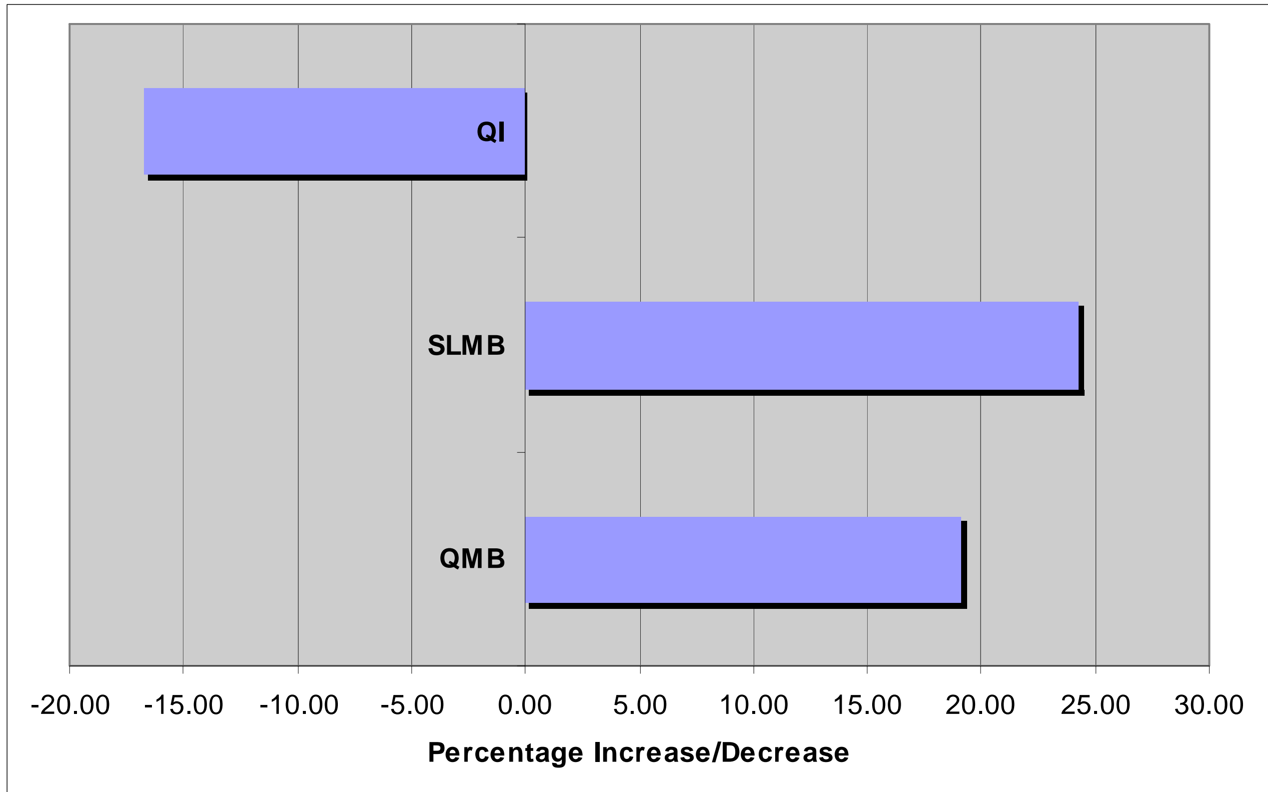
1. Elimination of the Asset Test

In 2008, New York fully eliminated the asset test for Medicare Savings Programs. This relatively new policy development has offered people who are income-eligible, but who may have saved a modest amount, the chance to enroll in an MSP and get deemed for the full LIS.[27] Elimination of the MSP asset test occurred incrementally. In 2002, the state began by eliminating the asset test for the QI benefit.[28] Then New York allowed individuals with assets above MSP limits who were income-eligible for SLMB and QMB—the other two MSPs, which still had asset tests— to enroll in QI. This practice, known informally as "QI dropdown," was utilized by the state for years, although federal eligibility standards stipulate that individuals enrolled in QI have incomes between 120 percent and 135 percent of FPL.[29, 30]

After six years of QI dropdown, and continuing advocacy by the New York State Medicare Savings Coalition, the state eliminated the asset test for all three MSPs, thus also eliminating the practice of

QI dropdown, effective April 1, 2008.[31] Individuals previously enrolled in QI through dropdown were reassigned to SLMB or QMB, both of which, unlike QI, are permanent federal entitlement benefits. Figure 1 indicates that from July through December 2008, average monthly enrollment in QI in New York shrank by 16.77 percent from the prior six-month period, while average monthly enrollment in SLMB and QMB increased by 24.23 percent and 19.10 percent respectively.[32]

Figure 1. Percentage Change in Average Monthly Enrollment in MSPs Following Asset Test Elimination in New York State, July–December 2008 (compared to January–June 2008)



Following the full elimination of the MSP asset test in New York, individuals newly enrolled in QMB were able to access the additional benefits granted by QMB, among them balance billing protections and payment for Medicare coinsurance and deductibles. For low-income New Yorkers with Medicare who cannot qualify for Medicaid owing to assets that are considered too high, QMB has become a critical health insurance fallback.

Additional improvements to MSP eligibility criteria in New York could be realized through increasing income limits for the MSP, thus allowing more people who currently have SLMB or QI to qualify for QMB, while allowing consumers who are currently over the limit for QI to qualify for the MSP for the first time. For example, New York could follow Maine's lead, as described below, by increasing the MSP income limit to 185% FPL, which would allow most, if not all, EPIC participants to automatically qualify for full Extra Help.

2. Targeting SPAP Members with Enrollment Assistance

In 2006, when the LIS benefit took effect, individuals enrolled in MSPs were automatically deemed for the LIS, which helped them pay for drug costs and also secured additional federal dollars for the state. Moreover, since the LIS has an asset test and MSPs do not, MSPs now serve as a "back door" to the LIS. Thus it is now possible to target New Yorkers with MSP enrollment assistance and thereby secure for them both MSP and LIS benefits, even if their assets are too high for the LIS alone. Such an enrollment tactic is financially advantageous for the state when applied to EPIC participants, as federal LIS coverage reduces state EPIC costs.

One initiative that capitalized on this situation saw the Medicare Rights Center and the New York State Health Insurance Information Counseling Assistance Program (HIICAP) working with EPIC to help EPIC members enroll in MSPs. Based on the success of this pilot program, in 2009 EPIC expanded its partnership with Medicare Rights Center to include Benefits Data Trust, a Philadelphia nonprofit committed to assisting low-income people gain access to benefits. As of January 2010, Benefits Data Trust mailed 19,800 MSP applications to EPIC members and submitted 6,413 completed MSP applications to county DSS offices.[33] Estimates indicate projected savings to the state of more than $30 million.[34, 35]

3. Elimination of Face-to-Face Interview Requirement for MSPs

Prior to December 26, 2007, people applying for an MSP in New York had to interview in person at their local DSS office, despite there being no federal requirement for an in-person interview.[36 37] An in-person interview is a particularly cumbersome requirement for MSP applicants, who frequently contend with visual or mobility limitations, do not have access to supportive transportation services and may not have access to family members or friends whom they could authorize to complete a face-to-face interview on their behalf. Further, stigma can prevent individuals from applying in person for benefits at what they perceive to be a "welfare" office.

The New York State Medicare Savings Coalition and other advocates focused attention on the needs of MSP applicants and demonstrated that MSP applications could be properly completed without the in-person interview. After careful review, NYSDOH determined that the elimination of the face-to-face interview requirement for Medicare Savings Programs would benefit people with Medicare while saving the state money through administrative efficiencies.[38] Efficiencies would be the result of 1) DSS staff spending less time meeting with MSP applicants, many of whom did not require in-person assistance, and 2) QMB applicants being allowed to apply for the benefit using the short MSP application form (DOH-4328).[39] As mentioned earlier, the state also aimed to promote MSP enrollment as a way of maximizing enrollment in the LIS and minimizing costs to EPIC.

Since the elimination of the face-to-face interview requirement, some New York DSS offices have reported that they now have more time to process MSPs and other benefit applications, and that the quality of the applications themselves has improved.[40] Perhaps more importantly, the elimination of the face-to-face interview requirement lays the groundwork for future policy reforms, such as creation of an online application and renewal system, which could even more profoundly increase access to the MSP and other benefits.

Barriers to Greater MSP Participation

1. Segmentation of Public Benefits in New York

With 15,000 employees serving over three million individuals, New York City's HRA is by far New York State's largest DSS office.[41, 42] Perhaps due to the sheer number of people receiving public benefits in New York City's five boroughs, and in an effort to better serve specific client needs, HRA has segmented its public benefits administration and processing departments into different sections within its central office, each responsible for only a few benefits. For example, Supplemental Nutrition Assistance Program (SNAP, or Food Stamps) applications are processed by one unit within HRA, while MSPs are processed by another. Individual offices process only specific benefits, and in many regards, they operate independently of one another. For instance, staff within the unit that processes MSPs will not process Food Stamp applications, and vice versa. In addition, the satellite HRA offices for medical programs, often located in city hospitals, usually do not process applications for food or cash programs. Applicants sometimes must go to multiple offices to complete multiple applications.

Such a segmented model of service delivery can hinder well-intentioned attempts to streamline the process by which people apply for public benefits.[43] Segmentation within an agency often leads to an increase in the amount of time an applicant must wait before they start receiving multiple benefits, and may discourage some applicants from applying for benefits altogether.[44] A person who wishes to apply for two or more benefits at the same time, such as Food Stamps and an MSP, may be asked to provide proof of income to the same agency two times. For example, if a New York City consumer uses the New York State common benefit application (LDSS-2921) to apply for Medicaid and Food Stamps, they may have to complete the exact same common benefit application form twice and submit it to two different locations for processing.[45] Applicants who are unaware of this practice may go to a DSS office to apply for both benefits using one application, but may only be considered for the benefit processed by that particular office.

Projects currently underway in New York and elsewhere seek to minimize the negative implications of the segmented model. In 2008, for example, the Medicare Rights Center and the Food Bank for New York City embarked on a joint initiative to enroll thousands of New Yorkers into Food Stamps, MSP, EPIC, and LIS.[46]

Utilizing cross-referrals, intensive training programs for local "Deputized Agents" or "Community Partners"—community-based organizations that want to help their own clients secure benefits—and joint enrollment events, this project promises to find new ways to maximize enrollment in these programs as efficiently as possible. As part of this project, staff from the Medicare Rights Center and the Food Bank For New York City conduct monthly workgroup meetings with representatives from the office of the Mayor, the New York City Department for the Aging, and HRA, with the goal of exploring and creating efficiencies in the Food Stamp and MSP application processes. The relationship with HRA, in particular, is important because the segmented divisions within HRA (health benefits and food benefits), are now speaking more frequently with each other and sharing information.

2. Recertification

As the MSP application process undergoes major changes nationwide through federal-level reforms, it is increasingly important that states redouble efforts to *keep* people enrolled in benefits for which they have already been approved. Otherwise, the risk increases of people losing benefits and having to appeal through costly fair hearings, or having to reapply for the same benefit, a process known as "churning."[47] Churning has been shown to be costly to states and inefficient from both the state and consumer perspective.[48] For example, while the comparison is not perfectly analogous to the MSP, it is estimated that it costs New York State $280 to process a single initial application for Medicaid for a child.[49]

29,962 New Yorkers with Medicare lost their 2009 deemed LIS status in 2010 because their preexisting MSP, Medicaid, or SSI case was closed.[50] While it is difficult to determine exactly what percentage of these "un-redeemed" individuals lost their MSP and LIS specifically due to cumbersome MSP recertification requirements, it is likely that the number of people who lose their deemed LIS status could be reduced through implementation of progressive MSP recertification policies. These policies also could potentially save the state significant amounts in administrative costs alone. Possible improvements, for which the New York State Medicare Savings Coalition has advocated, include conducting administrative renewals ("passive recertification"), extending a benefit's initial authorization period, extending the time period for recertifying for benefits, and eliminating the requirement that consumers resubmit documents that were previously submitted.[51]

New York is already taking steps to streamline and standardize the recertification process.[52] For instance, the state is in the process of creating a statewide Enrollment Center, as mandated by the 2008–9 state budget.[53] While few details about the Enrollment Center have been made public as of the publication of this report, one of its initial tasks will be telephonic recertification for Medicaid, a welcome state-level reform that could result in more comprehensive reforms in the future.[54, 55] For example, telephonic recertification could help illustrate that paperless recertification is not only possible, but also efficient, thus helping clear the way towards online or passive recertification.

Screening of Low-Income Subsidy Applicants for MSPs

As noted earlier, MIPPA requires that states treat transferred LIS application data as an MSP application. Fortunately for Medicare consumers in New York, NYSDOH has taken thoughtful steps towards automating as much of the SSA-to-state data exchange as possible, which, once implemented, could ease the burden on county DSS offices while necessitating little, if any, mandatory follow-up from consumers. MIPPA's data transfer provisions, as may eventually be implemented in New York through systems improvements, could serve as a national model for states that are currently requiring more follow-up and documentation than is necessary under the law.

In preparation for MIPPA data transfer implementation, New York opted to make better use of existing eligibility systems to automatically evaluate MSP eligibility for LIS applicants whose data was transferred. NYSDOH has indicated that when it receives the daily data file from SSA, it intends to run a cross-check to verify that the client does not already have Medicaid or an MSP. Once NYSDOH's automated process has been fully implemented, eligible applicants who do not have an open Medicaid or MSP case will be approved for the MSP, without the need for additional

signatures, follow-up or documentation. In short, NYSDOH trusts the data it receives from SSA to be valid and accurate, thus potentially resulting in a paperless MSP application for some New Yorkers with Medicare.

While New York's plan will not entirely eliminate the need for the county-administered, paper MSP application—and recertification challenges are expected—it is likely to reduce the need for paper applications, and to provide a new pathway to access MSPs for some individuals. This is the first time in New York's history that initial MSP applications will be processed at the state level, a reform that promises to reduce burdens on county DSS offices and to streamline enrollment systems statewide.

Maine

Advocacy Efforts

Many of Maine's MSP eligibility reforms stem from a coordinated effort by consumer advocates and state policymakers to maximize enrollment in MSPs and the LIS for members of the state's Low Cost Drugs for the Elderly and Disabled (DEL) program, which stands out as the country's first SPAP, implemented in 1975.[56] In particular, advocacy groups and the state government worked diligently to ensure that at the inception of Part D in 2006, consumers were knowledgeable about benefits coordination and low-income assistance options. Significantly, MSPs and the LIS were publicized as "ways to save" rather than as government assistance.[57] Due to a possible wariness of such assistance, Maine also took steps to communicate that MSPs were exempt from estate recovery provisions. The Maine MSP application itself indicates that Maine will not seek estate recovery for people who receive only an MSP.[58]

Maine also took steps to ensure that the transition to Part D went smoothly for people with Medicare. For example, the state created a Medicare Part D Stakeholders' Group, run through the office of the Governor and including representatives from state agencies and various Medicare advocacy groups.[59] In recent months, this stakeholders group, similar in makeup to the New York State Medicare Savings Coalition, has made successful implementation of MIPPA's data transfer provisions one of its priorities.[60] In addition to this government-created group, Medicare advocates and government staff meet regularly as part of the Maine Medicare Work Group, identifying ways to continue outreach and education around Medicare low-income programs.

State Reforms

1. Elimination of the Asset Test and Increased MSP Income Limits

By 2006, when the Part D drug benefit took effect, Maine had eliminated the asset test for its MSPs, a reform that resulted in 7,228 additional enrollments over the course of one year, and with it, an increase in the number of people deemed for the LIS.[61, 62]

In addition to eliminating the MSP asset test, Maine further aligned MSPs with DEL by raising the top MSP income threshold (for QI) to 185 percent of FPL, the income ceiling for DEL, in April 2007.[63] Without these reforms, DEL members with incomes and assets above the limits for LIS would pay more for their drugs. In addition, without these reforms, DEL would pay more to provide secondary coverage to Part D, as total drug costs would not be reduced through LIS.

MSP eligibility expansion in Maine was not specific to people in the DEL program. In fact, every preexisting MSP consumer in Maine, no matter which MSP they were enrolled in, became eligible for QMB after the expansion.[64] Maine was thereby able to leverage federal dollars to pay for Medicare coinsurance and deductibles for people who previously only had assistance paying for their Part B premiums.

2. Automatic MSP Enrollment for DEL Participants

Perhaps most significant of all of Maine's MSP reforms was the Maine Department of Health and Human Services' decision to automatically enroll all Medicare-eligible DEL members into MSPs, without consumers having to complete an application or provide additional documentation.[65, 66] Since the DEL and MSP criteria were now aligned, Maine was able to process MSPs based on financial data collected when the consumer first applied for DEL.[67] Through this highly streamlined process, administrative costs were minimized, as Maine did not have to pay an outside contractor to contact thousands of DEL enrollees and process thousands of applications. In fact, the Maine Department of Health and Human Services did not need to contact these consumers at all prior to deeming them eligible for an MSP.[68]

MSP eligibility reforms implemented by Maine are among the most proactive steps any state has taken to help people with Medicare save money on Medicare cost-sharing while maximizing federal dollars to the state. By using existing SPAP data, Maine was able to deem 13,500 DEL members automatically eligible for the MSP in one month.[69]

Barriers to Greater MSP Participation

1. Recertification

Despite progressive reforms, challenges remain for Maine residents trying to access MSPs and the LIS. As in most other states, Maine requires that MSP enrollees affirmatively recertify for the benefit annually.[70] Thus some consumers are likely affected by churning.[71] Maine's rural geography, cold winters and lack of widespread public transit also present challenges for consumers trying to enroll in MSPs. Maine has implemented an effective mail-in process for initial MSP applications, but people who need additional help or want in-person counseling may have difficulty finding it. In order to assist these individuals, staff and volunteers from the State Health Insurance Assistance Program (SHIP) sometimes make home visits.[72]

2. Screening of Low-Income Subsidy Applicants for MSPs

States like Maine, which have already taken important strides to align eligibility for multiple programs and create a single point of entry for benefits, are particularly well suited to take advantage of MIPPA's data transfer provisions. Like New York, Maine is in a position to do more than many other states to make the data transfer process as seamless as possible for Medicare consumers. Specifically, it has been reported that Maine will automate much of this process, and require little, if any, follow-up from Medicare consumers.[73] Maine intends to send adjudicated LIS data to one of the state's regional Medicaid offices, at which point it will be entered into the state's eligibility system. The consumer will be contacted only if additional information is required in order to make an MSP eligibility determination. Otherwise, an MSP eligibility determination will be made automatically.[74]

Kansas

Advocacy Efforts

In an effort to identify ways to reduce barriers and achieve reforms that would improve access to MSPs and the LIS, the Kansas Association of Area Agencies on Aging (K4A) in 2009 launched a Medicare Savings Coalition partially modeled after the New York Medicare Savings Coalition.[75] K4A estimates that up to 18,000 Kansans are eligible for Medicare low-income programs but are not enrolled.[76] This amounts to approximately 4.3 percent of the Medicare-eligible population in Kansas.[77]

The Kansas Medicare Savings Coalition and other advocates have worked to increase MSP awareness and enrollment in various ways.[78] For instance, the Coalition launched a public awareness campaign, which broadcasted public service announcements via radio and created a toll-free hotline that consumers could call to receive enrollment assistance from counselors at Kansas Area Agencies on Aging.[79] The Coalition also educates Medicare advocates on MIPPA-related eligibility changes and how these changes can help consumers.[80]

The **Kansas Health Policy Authority** (KHPA), the entity that creates and administers MSP policy in Kansas, is charged with the task of setting a public benefits policy agenda. KHPA is governed by a nine-member board of directors, responsible for determining which policy recommendations are implemented and which are not. KHPA staff analyzes enrollment trends and strategies, and makes policy recommendations to the board.

*The Kansas legislature established the Kansas Health Policy Authority as an agency in the executive branch of state government. Part of its charge is to "develop and maintain a coordinated health policy agenda that combines effective purchasing and administration of health care with health promotion oriented public health strategies. The powers, duties and functions of the Kansas Health Policy Authority are intended to be exercised to improve the health of the people of Kansas by increasing the quality, efficiency and effectiveness of health services and public health programs."**

The **Kansas Department of Social and Rehabilitation Services** (SRS) is charged with processing benefit applications and renewals based on the administrative policies enacted by KHPA. SRS is further assisted with application processing by private outside contractors.

* From http://www.khpa.ks.gov/health_reform/historical_overview.html

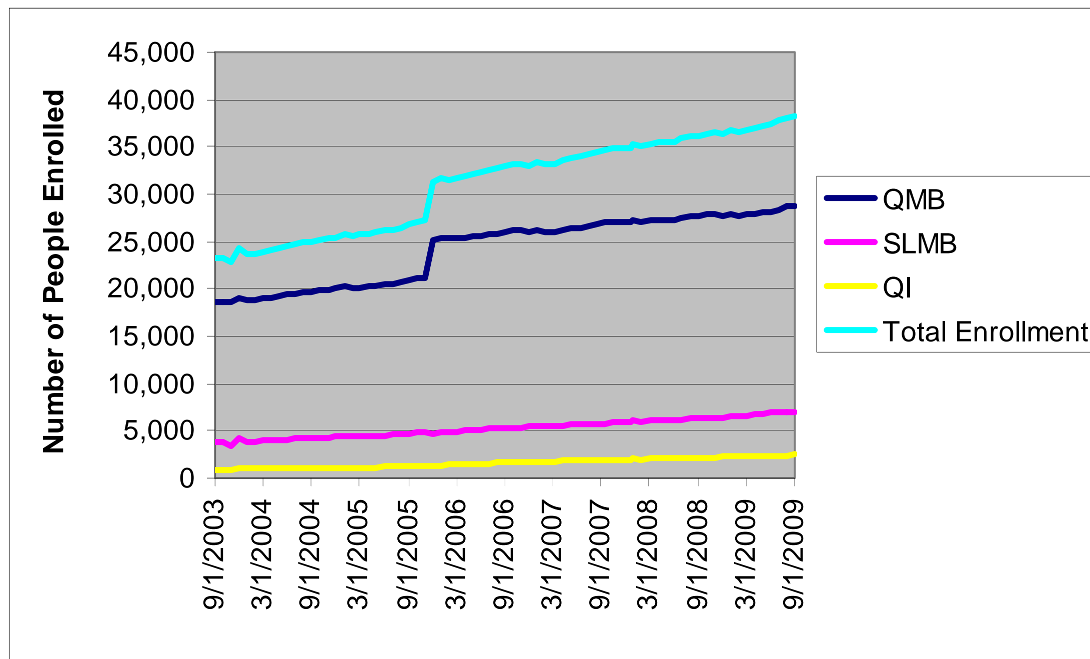
As the Kansas Medicare Savings Coalition grows, it is looking to build on existing relationships with the Kansas Health Policy Authority (KHPA), the entity that creates and administers MSP policy in Kansas, and the Kansas Department of Social and Rehabilitation Services (SRS), the agency charged with processing benefit applications and renewals based on the administrative policies enacted by KHPA (see text box above). In particular, KHPA's Outreach Advisory Council, which launched in August 2008, could be a strong state-level partner for Kansas's various Medicare advocacy groups.[81]

The New York Medicare Savings Coalition and Maine's Part D Stakeholders' Group have served as models for building strong government-advocate collaborations in Kansas. An immediate goal of such partnerships could include a campaign for the KHPA board to lift prohibitions on benefit expansion, at least for programs such as MSPs that bring federal dollars to the state while helping people with Medicare afford needed care.

State Reforms

MSP enrollment in Kansas has steadily increased over recent years as the result of a series of reforms undertaken by the state.

Figure 2. MSP Enrollment Rates in Kansas, 2003–2009



1. Elimination of Estate Recovery for MSPs

MIPPA eliminated estate recovery for MSPs across the country, effective January 1, 2010.[82] However, prior to this national policy change, some states had already taken steps to limit the practice of estate recovery following the deaths of former MSP recipients. In Kansas, many Medicare consumers, fearing government intervention in personal affairs, worry that participation in a Medicaid-funded benefit could give the state the right to recover its costs following their death. In an effort to encourage more people to apply for MSPs, Kansas formally eliminated the practice of estate recovery for MSP consumers effective January 1, 2003.[83] To promote this reform, state MSP brochures note this policy prominently. In addition, the MSP application itself states that estate recovery does not apply to these programs.[84]

2. Development of an MSP-Specific Application

Earlier incarnations of the Kansas MSP application were "common applications," which were also used to assess eligibility for Food Stamps and Medicaid.[85] Medicare consumers were not given the option of using a specialized MSP application. Combined benefit application forms often include questions that are not required to determine whether an individual is eligible for benefits, and may dissuade people from completing the application process. A specialized, shortened MSP application form was thus implemented at the inception of Medicare Part D in 2006, as a way to maximize LIS deeming and simplify the application process for people who wish to apply for MSPs only.[86] People who would like to apply for multiple benefits may still use a combined benefit application form.[87]

Barriers to Greater MSP Participation and Advocacy Opportunities

1. State Spending on Public Benefits Administration and Processing

Increased enrollment in public benefits in Kansas has coincided with efforts over time to reduce state spending on public benefits administration. Insofar as these reductions have eliminated agency personnel without a major corresponding effort to streamline enrollment processes, agencies face increased workloads that can make it increasingly difficult for them to process MSP and Medicaid applications within the legal deadline of 45 days.[88] Failure to meet this deadline puts Kansas's federal cost-sharing at risk and causes thousands of Medicare consumers to wait long periods before benefits take effect.[89]

Kansas continues to cut costs. For instance, it eliminated $1.1 million from the Medicaid administration budget in December 2009.[90] These recession-linked budget cuts have resulted in further application backlogs and increased wait times at the call center that helps consumers understand MSPs.[91] Perhaps the most significant effect of the budget crisis has been that KHPA is currently under a directive from its board of directors that it may not expand eligibility for any programs, including MSPs, at this time.[92]

2. Income and Asset Tests

The income and asset eligibility limits for MSPs in Kansas, and many other states, are set at the lowest levels allowed by the federal government.[93] In fact, the 2009 MSP asset limits in Kansas were the same as they were 20 years ago when the MSP programs were first established. MIPPA legislation increased the state's MSP asset limits on January 1, 2010, to align with LIS limits, but the state could eliminate the asset test entirely and/or increase income limits to further expand eligibility.[94]

As recently as 2009, KHPA drafted a report identifying expanded MSP income and asset limits as potential reforms.[95, 96] The KHPA report considers combining an increase in MSP income limits with a full elimination of the asset test for all three MSPs.[97] In their report, KHPA posits that Kansas would leverage $10 in federal health care spending for every state dollar spent on the state share of MSP benefits under the proposed higher MSP income and asset limits.[98] This savings results from the fact that maximizing enrollment in MSPs helps ensure that people can fully participate in Medicare, as opposed to having to rely on state-sponsored Medicaid. The potential return on this initial investment in MSP expansion could be considerable.

3. Lack of an Online Application for All Public Benefits

Following its creation of a specialized MSP application, KHPA began to consider the development of an online application for MSPs and other medical assistance programs, a reform that has not been fully realized in most states. By enabling low-income people with Medicare to access multiple benefits through a single point of entry, online benefit application forms can be useful enrollment tools for advocates and consumers.[99] While SRS offers a limited online application form for Food Stamps and cash assistance, applicants for MSPs must currently use the paper form.[100] Thus in some cases, individuals who are applying for multiple benefits have to report and document the same eligibility information twice. KHPA has sought grant funding to make improvements to Kansas's eligibility and enrollment systems, including the introduction of a comprehensive online application form.[101] KHPA, in collaboration with SRS, is currently taking concrete steps to design this online system.[102]

4. Recertification

Kansans with MSPs typically recertify for MSPs through the mail.[103] Applications and renewals are also accepted by fax or in person.[104] Individuals renewing their MSP must complete the same form they used at the time of initial application, as there is no separate form used solely for MSP recertification.[105] In addition, SRS does not prepopulate the MSP forms for people to use when recertifying. This practice effectively requires the MSP enrollee to repeat the initial application process each year, using the same form and documenting the same information.[106] To mitigate this annual redundancy, SRS representatives often attempt to contact people who do not respond to the recertification notices with a follow-up letter or phone call.[107] Unfortunately, SRS's ability to make these calls in the future will be challenged by staff resources, thus increasing the likelihood that MSP retention rates in Kansas may fall.[108]

Beyond what would be achieved by an online application, KHPA has considered further limiting the role of state workers in benefits processing, as a way to reduce state expenditures even more.[109] Beneficial reductions could be achieved in a number of ways—by implementing passive MSP recertification, for instance, or by allowing income and asset attestation, rather than documentation, at the time of MSP application and recertification. KHPA is currently considering income attestation for renewals of some Medicaid programs, but not for initial applications.[110] KHPA is also considering pre-populating recertification forms for Medicaid programs, as well as implementing a passive recertification process, although it is unclear if these reforms would include the MSPs.[111]

KHPA staff is somewhat pessimistic that income and asset attestation will be implemented in Kansas in the near-term.[112] A perceived downside to these reforms is the increased expense associated with higher program enrollment. But this negative consequence is likely to be at least partially offset by a sharp reduction in administrative costs, as was the case in Maine. For example, a move toward passive recertification could fully eliminate the need for SRS staff to contact people who do not respond to recertification notices.

Screening of Low-Income Subsidy Applicants for MSPs

Unlike New York and Maine, which ultimately may not require additional documentation from most MSP applicants, Kansas will require additional MSP eligibility information and

documentation from the majority of individuals whose data is transferred from the Social Security Administration. This practice may undercut the intent of MIPPA, which is to maximize the use of previously collected and verified eligibility data to enroll more people in MSPs and the LIS. Further, the proposed practice will not reduce—and may in fact increase—the state's administrative costs. Kansas has estimated that, owing to MIPPA data-transfers, the state will process an average of 600 more MSP applications per month than are currently processed.[113]

Florida

Advocacy Efforts

Florida serves as an example of how a state's public agencies can transform existing systems. The Florida Department of Children and Families (DCF) in 2003 instituted broad administrative reforms that benefit consumers and help reduce state expenditures; these reforms effectively turned a segmented system into a centralized one.

As a result of DCF's reforms, applicants for public benefits in Florida now complete a single application, which is processed by "modernized" systems.[114] DCF modernization has reduced documentation burden for state consumers and administrative burden for DCF staff.[115] New systems have also primed the state to adopt additional eligibility reforms to benefit consumers in the future.

Since 2005, DCF has worked diligently to develop partnerships with community-based organizations (CBOs) and other advocacy groups that can help consumers learn about and apply for low-income benefits.[116] Most recently, the Florida Association of Area Agencies on Aging (F4A), in partnership with staff from the University of North Florida and Medicare Rights Center, has developed a Medicare Savings Coalition modeled after the New York and Kansas Medicare Savings Coalitions. This new coalition is expected to seek and identify opportunities for continued MSP reforms in Florida.

State Reforms

1. Streamlined Benefits Application

The cornerstone of DCF modernization was the implementation of ACCESS (Automated Community Connection to Economic Self-Sufficiency), an online tool used for application, recertification, and management of various public benefits.[117] ACCESS was launched in 2005, and today is the primary method by which people apply for public benefits in Florida.[118] ACCESS serves as an example of how states can realize administrative savings through user-friendly, online applications, or through coordination with a national point-of-entry that can be tailored to enroll individuals in state benefits.[119]

Today, many Floridians apply directly for benefits through ACCESS, at home or at a DCF "storefront" office (described below). The ACCESS program screens applicants of all ages for multiple low-income programs and transmits the collected data from a single application to a processing center staffed by DCF employees.[120] Using systematic data-matching, these employees review the submitted information for accuracy and then authorize MSP coverage, deny it, or request additional information from the consumer. The entire MSP application process, once initiated on ACCESS, takes anywhere from 10 minutes to two hours, depending on an applicant's responses.[121]

Once an application is submitted, applicants may decide to create a personalized ACCESS account so that they can review their case later on. Applicants for Medicaid and MSPs are no longer required to have a face-to-face interview, but may choose to have one, or may be required to have one if applying for additional benefits.[122]

Visit to a Florida DCF ACCESS Storefront, September 23, 2009

The DCF-run ACCESS office in Tallahassee, Florida, where people may apply for public benefits such as MSPs, is located in a mini-mall in a central part of the city. From the outside, the office does not look like a "welfare office," and the exterior makes no reference to Food Stamps or Medicaid. Indeed, the office itself is referred to as a "storefront," which may reduce stigma surrounding Medicaid and other welfare offices. Partially closed blinds give the applicants inside the ACCESS office privacy as they navigate the ACCESS system on their private computers, the monitors of which are sunken into the tables to protect the consumers' private data from others in the office.

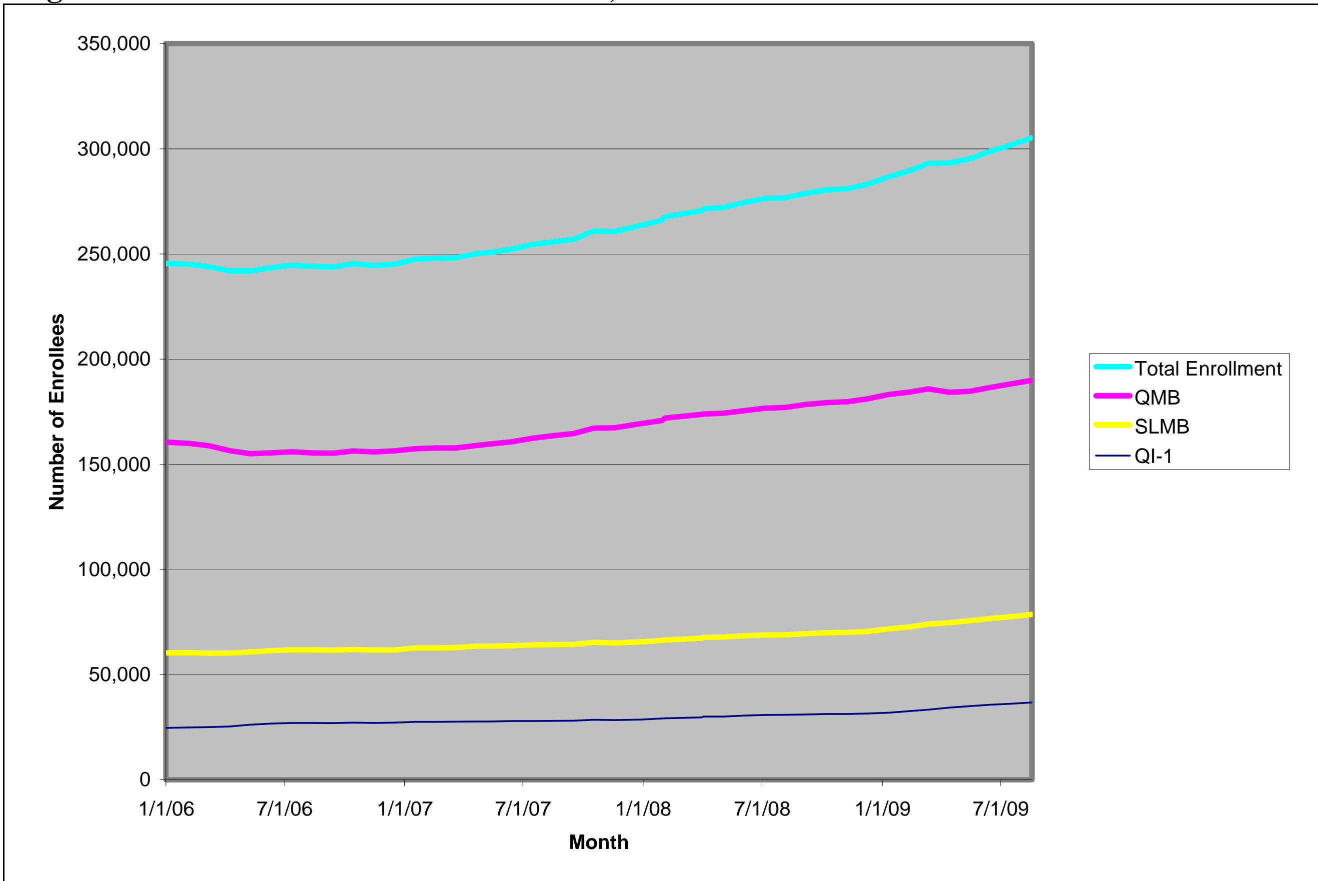
The inside of the ACCESS office resembles an internet café. There are no lines or people waiting to be helped. There are enough computer workstations to accommodate the crowd, and each consumer works independently on a computer. Five staff members are visible to consumers and ready to help, with one supervisor conducting interviews when required, and four additional staff members providing technical support.

Consumers in the ACCESS office have free use of a fax machine, copier, and telephones with a direct link to a helpline. Brochures are visible to help consumers gain a better understanding of certain benefits, and one of the office's computers is available for researching outside resources.

One major advantage of the ACCESS system is that it may be accessed 24 hours per day, seven days per week, from any computer in the world, thus providing out-of-state family members and other caregivers the opportunity to complete an application easily on someone else's behalf.[123] ACCESS is also well designed in that multiple enrollments may be realized from a single application submission, thus reducing instances of attestation and documentation duplication.[124] ACCESS may be used for benefit screening, application, and recertification, as well as for providing a real-time snapshot of a consumer's enrollment status and proof of enrollment, tasks that would likely take much longer in states like New York, where only DSS workers have direct access to consumer eligibility data. From a client's perspective, ACCESS has the potential to provide a very positive user experience for consumers and their families.

As the data in Figure 3 show, Florida has achieved higher MSP enrollment rates in recent years in part through ACCESS's improved technologies. During modernization, which ultimately saved the state $100 million in annual operating costs, DCF staff was reduced by 36 percent, or 3,000 employees statewide.[125, 126] DCF also closed approximately 40 percent of its "customer service centers" (formerly ACCESS storefronts), the offices at which consumers applied for benefits and received in-person application assistance.[127] Higher benefits processing rates have therefore been achieved through enhanced use of technology.

Figure 3. MSP Enrollment Rates in Florida, 2006–2009



2. Streamlined Recertification

DCF's modernization affected MSP recertification by making it possible for people with MSPs to renew all of their benefits in one sitting, at the same time each year.[128] As such, the risk of churning is reduced, resulting in easier application and recertification processes for consumers and economic efficiencies for DCF. What is more, at the time of their annual recertification, Floridians are asked only to report on factors likely to change, further simplifying the recertification process.[129]

DCF has indicated that it plans to reform its recertification process even further for Medicaid-only households, including households with people enrolled in MSPs through passive recertification.[130] Since this process will be used only with Medicaid-only households, MSP enrollees who also have Food Stamps or other benefits will continue to actively recertify. As passive recertification is implemented, DCF expects churning and enrollment drop-off rates to be reduced even further statewide.[131, 132] Coupled with a system based almost exclusively on attestation of income and assets—rather than on documentation—Florida's modernization effort offers a useful model for states seeking to make it easier for consumers to secure public benefits.[133]

Barriers to Greater MSP Participation and Advocacy Opportunities

1. Staff Reductions and Lack of Financial Support for CBOs

While ACCESS offers a streamlined MSP application experience for the majority of consumers, DCF has indicated that its statewide call center, staffed by 400 DCF representatives, still receives around 24,000 calls daily.[134] Some consumer advocates who help people apply for public benefits in Florida have expressed the view that the call center is unable to help all callers in need of assistance.[135] In particular, some public benefits require more documentation than the MSP, or are simply far more complicated than MSPs. For people applying for those particular public benefits, reductions in DCF staff cannot be fully offset by technological efficiencies. In many cases, CBOs have taken on the responsibility of counseling the state's low-income consumers and their families. The Florida Medicare Savings Coalition and other Florida-based Medicare advocacy groups could campaign for increased education of DCF staff and in-person assistance for MSP-eligible individuals.

To date, DCF has cultivated partnerships with more than 3,000 CBOs.[136] These partners enter into agreements with DCF and become consumers' facilitated entry point into ACCESS.[137] Community partners generally receive little or no financial compensation from DCF, even though they are contributing their time and expertise to help DCF increase state enrollment rates. Without the work of community partners, DCF would not be able to perform its expanded role, which grew out of DCF's own major modernization reforms.[138] Community partners could be better equipped to assist Medicare consumers apply for, understand, and use their public benefits if DCF provided them with increased financial support.

DCF communicates with community partners through its storefronts and "partner liaisons," some of which sponsor trainings and policy forums.[139] DCF also writes and distributes newsletters to community partners. F4A's creation of a statewide Medicare Savings Coalition, similar in scope to those operating in New York and Kansas, could help keep a spotlight on programs like MSPs for advocates and policymakers. Given the enormous responsibilities of DCF's community partners, there may be a need to strengthen communication between DCF and the community, and to provide a forum whereby stakeholders can share ideas that could benefit people with Medicare.

2. Income and Asset Tests

Florida's 2009 MSP asset limits were set at $5,000 for an individual, which was $1,000 above the federal minimum standard for a household of one. Since 1989, the asset limit for married couples had been $6,000. Without an SPAP, states like Florida have less financial incentive to maximize LIS deeming through MSP eligibility expansions. Indeed, DCF is not currently considering an expansion of MSP eligibility beyond the expansions enacted through MIPPA, which raised Florida's and dozens of other states' MSP asset limits to align with those for LIS, effective January 1, 2010.[140, 141] Since DCF has already implemented sweeping improvements to Florida's benefits application process, the Florida Medicare Savings Coalition could consider pursuing advocacy strategies to further expand Florida's income and asset limits for MSPs.

3. Initial Application Process

For Medicare consumers applying for benefits online, ACCESS could be improved by adding "pop-up" functionality, such that consumers can learn about benefits while using the ACCESS program. DCF staff has indicated that they are in favor of implementing this functionality, as it will lead to better-educated applicants.[142]

Medicare consumers who do not want to use an automated system and prefer to use the older paper MSP application will find the form relatively short, simple, and easy to complete. The July 2006 version of the application (CF-ES 2282) may be completed using a computer, then printed, or it may be completed by hand. The paper application could be improved by referring to the benefit as a "Medicare Savings Program" instead of "Medicaid/Medicare Buy-In," which may be confusing for consumers, and is not CMS's preferred name for MSPs when working with Medicare consumers. The application also does not explain what the MSP is or the benefits it offers. One way to provide this information could be to include an MSP fact sheet or brochure with paper applications.

Screening of Low-Income Subsidy Applicants for MSPs

There is room to improve upon DCF's plans to implement MIPPA's data transfer provisions. In order to process LIS data as an MSP application, DCF will, upon receiving LIS data from SSA, run a comparison against its current files to ensure that the individual does not already have an open Medicaid case. DCF will consider applications from people who do not have an open Medicaid case as "pending," and will mail them letters explaining that they will need to further attest income and asset sources.[143] Individuals who respond to the mailing and are found eligible will then be approved for the benefit, and their cases will be handled identically as those of any other MSP enrollee with regard to benefit management and recertification.[144] Individuals who do not respond to this single mailing will have their MSP denied.[145]

DCF has indicated that the LIS application does not capture all the information they need to make a full MSP determination, and that some information sent by SSA is not in a format that can be used readily by the state, despite the fact that states such as New York, Maine, Massachusetts, and Louisiana are taking steps towards making MSP determinations based solely on this adjudicated SSA data.[146, 147] Thus, although MIPPA aimed to streamline application processes, Florida will still require low-income Medicare consumers to apply separately for LIS and then provide additional information to DCF for consideration of MSP eligibility. Moreover, unlike individuals who apply for MSPs using ACCESS, individuals whose LIS data reach DCF through the MIPPA data transfer process will not be screened for other public benefits.[148] The Florida Medicare Savings Coalition could advocate that DCF make an MSP determination based on the data it receives from SSA for as many consumers as possible, as opposed to requiring additional information or documentation on all cases.

Conclusion

Absent increased education, assistance, and multi-stakeholder collaboration, public benefits alone are not enough to remedy a too-frequent lack of access to affordable health care among older Americans and those with disabilities. Despite the substantial financial assistance that MSPs, the LIS, and related programs offer people with Medicare, enrollment in these programs remains low. By taking strides to reverse under-enrollment trends for MSPs and the LIS, consumers, state and

national consumer advocates, and policymakers would not only increase immediate access to critical public benefits, but would pave the way to more effective implementation of future benefits-related reforms.

States' responses to economic and political realities have had a direct effect on MSP enrollment and how well people with Medicare are able to access the health care they need. State policymakers, with their considerable clout in determining how MSPs are administered, are especially well positioned to take steps to increase access to valuable public benefits such as MSPs and the LIS.

States can take a number of actions to increase access to these benefits among people with Medicare. A state can pursue state-based reforms to reduce legislative and administrative barriers to access to public benefits. In New York, for instance, the legislature's elimination of the asset test and face-to-face interview requirement for MSPs helped increase enrollment rates and ensure that individuals were enrolled in the appropriate MSP. Or a state may determine that its older consumers might be well served simply by receiving more education about public benefits. In Kansas, increased educational outreach and the creation of a toll-free assistance hotline have helped build consumer awareness of MSPs and the LIS, without the state having to liberalize eligibility standards or otherwise enact new policies. In some states, too, a total overhaul of existing benefits structures may be a viable way to increase access to public benefits. In Florida, the restructuring of benefits administration systems, such that individuals apply for all benefits through a single point of entry, has gone a long way toward helping consumers access and keep needed assistance. Finally, states and advocates could encourage federal lawmakers to pursue legislation that would further raise or eliminate LIS and MSP asset tests nationwide, as well as increase income limits.

As state and federal policymakers work to improve public benefits enrollment through policy and educational initiatives, it is crucial that consumer advocates help keep the consumer at the center of the conversation. For instance, Area Agencies on Aging in Kansas and Florida, which counsel thousands of consumers each year, are well suited for developing materials for older adults and carrying their concerns to state and federal agencies. In New York, consumer groups such as the Medicare Rights Center engage older adults to advocate for reforms, at community events and in letters and articles. And while advocates are necessary for helping achieve reforms, their importance—and the importance of the consumer experience they convey—only grows as reforms are implemented. To take one example, MIPPA's passage marked an important moment for people with Medicare, insofar as the legislation created the *potential* for streamlined enrollment and recertification in MSPs and the LIS. But the *reality* for consumers in most states currently remains as it was before MIPPA. While legislation itself was a necessary step for helping consumers, success now lies in effective implementation, and focused advocacy is more critical than ever for ensuring that MIPPA's data transfer provisions fulfill their intended purpose. Similarly, for people with Medicare, the reforms included in the Patient Protection and Affordable Care Act could mean increased ease in choosing doctors and health plans, reduced prescription drug costs, and improved health through new preventive care and care coordination policies. But advocates, who observe the real hurdles to care among older adults and those with disabilities, must come together with these individuals and with state and federal entities to ensure that new policies truly serve consumers.

In conclusion, without agencies and advocates committed to timely education, consumer-oriented reforms, and transparency—girded by adequate financial support and oversight—the U.S. will be unable to offer the fullest range of supports to its older residents and those with disabilities, nor will it understand promising practices that could be ripe for replication. The array of lessons learned in

New York, Maine, Kansas, and Florida that are described in this report can serve as excellent models for other states seeking to develop effective advocacy and educational strategies for increasing older consumers' awareness of and access to public benefits. The promise of good, affordable health care for Medicare consumers and all Americans can best be realized through increased cooperation among local, state, and federal stakeholders, with reforms and their implementation fueled by the consumer experience.

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[1] 42 U.S.C. §1396(a)(10)(E) (2009).

[2] Additional details on how the Medicare Savings Programs help pay Medicare costs may be found at www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=390, accessed June 30, 2010.

[3] Federman, A., Vladeck, B., and Siu, A. "Avoidance of Health Care Services Because of Cost: Impact of the Medicare Savings Program," *Health Affairs* 24, no. 1 (2005): 263–270.

[4] Income sources may be counted differently among states. While all states count most forms of unearned income such as Social Security or monthly pensions, differences exist on how or whether certain income sources are counted towards MSP eligibility. *See* Kaiser Family Foundation, "Income Requirements for Qualified Medicare Beneficiaries (QMBs) receiving Medicaid Assistance including Income Limits, Asset Limits and Disregards, 2010." Available at www.statehealthfacts.kff.org/comparereport.jsp?rep=61&cat=6&rgnhl=27, accessed June 30, 2010. Additional details may be found by contacting state Medicaid agencies.

[5] States use different rules to count assets to determine if MSP applicants meet these guidelines. Even if an MSP applicant's assets are above the thresholds in the guidelines, they may still qualify, because some assets, such as primary residence or vehicle, may not be counted.

[6] Summer, L. *Increasing Participation in Benefit Programs for Low-Income Seniors*, Commonwealth Fund, May 2009. Available at www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/May/1266_Summer_increasing_particip_benefit_progs_v3.pdf, accessed on June 30, 2010.

[7] Ibid.

[8] Social Security Administration, "What You Need To Complete The Application For Extra Help With Medicare Prescription Drug Plan Costs," January 2010. Available at www.ssa.gov/pubs/10128.html, accessed on May 11, 2010.

[9] Centers for Medicare & Medicaid Services, "Guidance to States on the Low-Income Subsidy," May 25, 2005.

[10] Centers for Medicare & Medicaid Services, SMDL #10-003, February 18, 2010. Available at www.medicarerights.org/pdf/MIPPA-SMD-Letter-2-18-10-final.pdf, accessed on April 12, 2010.

[11] Ibid.

[12] Goggin-Callahan, D., *Warning Signs: Preliminary Report Highlights Problems with State Implementation of MIPPA Low-Income Reforms*, Medicare Rights Center, February 2010. Available at www.medicarerights.org/pdf/Warning-Signs-MIPPA.pdf, accessed June 30, 2010.

[13] Kaiser Family Foundation, "Qualified State Pharmaceutical Assistance Programs (SPAPs), 2007. Available at www.statehealthfacts.org/comparetable.jsp?cat=6&ind=314, accessed on May 11, 2010.

[14] Since the inception of Part D, states are required to pay back to the federal government a percentage of the drug coverage for the dually eligible. *See* Schneider, A., *The "Clawback:" State*

Financing of Medicare Drug Coverage, Kaiser Commission on Medicaid and the Uninsured, June 2004.

[15] Zuckerman, S., Shang, B., and Waidmann, T. "Medicare Savings Programs: Analyzing Options for Expanding Eligibility," *Inquiry* 46, no. 4 (Winter 2009/2010): 391–404.

[16] The states that have fully eliminated the MSP asset test are Alabama, Arizona, Connecticut, Delaware, Maine, Mississippi, New York, and Vermont.

[17] The states offering income disregards above the $20 standard unearned income disregard are Connecticut, Illinois, Maine, Mississippi, and the District of Columbia.

[18] Sia, J., Fox, K., Reinhard, S., *Improving Access to Health Care in a Changing Landscape: Facilitating Enrollment in Medicare Savings Programs and Medicare Part D*, State Solutions, 2005.

[19] Summer, *Increasing Participation in Benefit Programs for Low-Income Seniors*.

[20] New York State Medicare Savings Coalition, Mission Statement. Available at www.medicarerights.org/NY_Medicare_Savings_Coalition_Mission_2009.pdf, accessed on November 29, 2009.

[21] Ibid.

[22] Robert Wood Johnson Foundation, *State Solutions: An Initiative to Improve Enrollment in Medicare Savings Programs,* October 2009. Available at www.rwjf.org/reports/npreports/statesolutions.htm, accessed on November 29, 2009.

[23] Medicare Rights Center's New York City Deputization Project. Description available at www.medicarerights.org/about-mrc/services_professionals.php, accessed on November 27, 2009.

[24] Medicare Rights Center, "Medicare Savings Programs and the Face-to-Face Requirement," as presented to the New York Medicare Savings Coalition, August, 2007. Available at www.medicarerights.org/MSP_face_to_face_talking_points.pdf, accessed on November 27, 2009.

[25] Medicare Rights Center, "Lifting the Asset Test for Medicare Savings Programs in New York State," as presented to the New York Medicare Savings Coalition, August, 2007. Available at www.medicarerights.org/asset_test_elimination.pdf, accessed on November 27, 2009.

[26] Passive recertification is the process by which enrollees receive a notice listing their current eligibility information, and need to respond only if the information has changed. *See* Lipson, K., Fishman, E., Boozang, P., and Bachrach, D., *Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Public Health Insurance Programs*, Commonwealth Fund, August 2003.

[27] In addition, while New York's MSP income limits are not higher than the federal minimum requirement, applicants are allowed to deduct certain expenses from their MSP budget, among them the cost of Medigap premiums and other private insurance. *See* State of New York, *Medicaid Reference Guide*, Income Section. Available at www.health.state.ny.us/health_care/medicaid/reference/mrg/income.pdf, accessed on November 17, 2009.

[28] State of New York, Office of Medicaid Management, GIS 02 MA/009, "Elimination of the Resource Test for Qualified Individuals (QIs) and Changes to the SLIMB Program," April 1, 2002.

[29] Ibid.

[30] 42 U.S.C. §1396(a)(7)(xix) (2009).

[31] State of New York, Office of Health Insurance Programs, GIS 08 MA/016, "Elimination of the Asset Test for the QMB and SLIMB Programs," June 27, 2008.

[32] These data, from CMS Third Party Billing Files, represent the number of monthly MSP enrollments for which states seek reimbursement from CMS. The data may not be perfectly

representative of actual MSP enrollments in a given month, as retroactive coverage may be included.

[33] EPIC Medicare Savings Project Report, January 21, 2010.

[34] This total is calculated by assuming that 5,000 New Yorkers will be enrolled in MSPs and the LIS through this effort. Each individual secures a value of $1,157 for MSP enrollment (the $96.40 monthly Part B premium) plus a value of $3,900 for Part D and LIS enrollment. EPIC estimates that the state's drug expenditures are reduced by $1,430 for each EPIC member enrolled in the LIS. Thus, $5.8M+19.5M+$7.15M=$32.5M.

[35] These efforts by EPIC to enroll its members into an MSP were unfortunately drawn out over the span of months because people with EPIC must still complete paper MSP applications and provide income documentation they previously reported to EPIC. To further illustrate how that practice is not synergistic, the agency in charge of MSP administration in New York is also the parent agency of EPIC. That is to say, NYSDOH, through EPIC, already has on file most, if not all, of the information they are requesting. Thus, people with EPIC who apply for an MSP may be asked to attest or document their income twice: once through EPIC's Request for Additional Information form and then again through the MSP application.

[36] State of New York, Office of Health Insurance Programs, GIS 07 MA/027, "Elimination of Face-to-Face Interview For Medicare Savings Programs," December 26, 2007.

[37] N.Y. Soc. Serv. Law § 366-a (2007).

[38] Medicare Rights Center, "Medicare Savings Programs and the Face-to-Face Requirement."

[39] This shorter, MSP-specific application form is available at www.health.state.ny.us/health_care/medicaid/program/update/savingsprogram/msapp.pdf, accessed June 30, 2010. Prior to the elimination of the face-to-face interview requirement, people applying for QMB had to use the much longer common benefit application form (LDSS-2921).

[40] Personal communication with Deborah Hankewich, Social Welfare Examiner II, Nassau County Department of Social Services, May 2009.

[41] New York City Human Resources Administration, "About HRA/DSS." Available at www.nyc.gov/html/hra/html/about/about_hra_dss.shtml, accessed on November 17, 2009.

[42] Dutton, M., Bernstein, W., Bhandarkar, K., and Ingargiola, S. *The Role of Local Government in Administering Medicaid in New York*, Medicaid Institute at United Hospital Fund, August 2009. Available at www.medicaidinstitute.org/assets/685, accessed on June 30, 2010.

[43] Segmentation is defined as the existence of multiple governments within a certain geographic area, or the practice of dividing responsibility for administration of various functions among multiple branches within a single entity. *See* Main, T.J., "Quantum Change in the Fragmented Metropolis: Political Environment and Homeless Policy in New York City," *Review of Policy Research* 23, no. 4 (2006) 903-913.

[44] One common result of segmentation is that consumers have limited access to a single entry point for multiple public benefits. However, a leading method of promoting enrollment in low-income programs is to screen individuals for multiple low-income programs at one time. *See* Summer, *Increasing Participation in Benefit Programs for Low-Income Seniors*.

[45] New York State Office of Temporary and Disability Assistance, LDSS 2921, January, 2005. Available at www.otda.state.ny.us/main/apps/2921.pdf, accessed on November 27, 2009.

[46] Medicare Rights Center and Food Bank for New York City, press release, July 6, 2009. Available at www.medicarerights.org/newsroom/pressreleases/2009_10.html, accessed on May 11, 2010.

[47] Summer, L., *Retaining Benefits: An Important Aspect of Increasing Enrollment*, Issue Brief #3, National Council on Aging, August 2009. Available at

www.ncoa.org/assets/files/pdf/NCBOE_issue_brief_retaining_benefits.pdf, accessed on June 30, 2010.

[48] Ibid.

[49] Fairbrother, G., Dutton, M.J., Bachrach, D., Newell, K., Boozang, P., and Cooper, R., "Costs Of Enrolling Children In Medicaid and SCHIP," *Health Affairs* 23, no. 1 (2004): 237–243.

[50] Centers for Medicare & Medicaid Services, *Year 2009 Re-deeming – Losing Deemed Status*. Available at www.cms.hhs.gov/LimitedIncomeandResources/, accessed on March 25, 2010.

[51] Summer, *Retaining Benefits*.

[52] Recertification will be discussed in greater detail in a forthcoming brief.

[53] Dutton et al., *The Role of Local Government in Administering Medicaid in New York*.

[54] Ibid.

[55] New York State Department of Health press release, "Statewide Health Insurance Enrollment Center Will Streamline Enrollment, Reduce Local Burden," Oct. 16, 2008. Available at www.health.state.ny.us/press/releases/2008/2008-10-16_enrollment_release.htm, accessed on December 1, 2009.

[56] Fox, K. *Prescription Drug Access, Quality and Affordability in Maine*. Policy brief prepared for the Legislative Policy Forum on Health Care at the University of Maine, January 26, 2007.

[57] Medicare Payment Advisory Commission (MedPAC*)*, "Increasing Participation in the Medicare Savings Programs and the Low-Income Drug Subsidy," chapter 5 in *Report to the Congress: Medicare Payment Policy*, March 2008. Available at http://www.medpac.gov/chapters/Mar08_Ch05.pdf, accessed on December 20, 2009.

[58] State of Maine Department of Health and Human Services. Application for MaineCare and Food Stamp Benefits, December 2006.

[59] Summer, L., O'Brien, E., Nemore, P., and Hsiao, K., *Medicare Part D: State and Local Efforts to Assist Vulnerable Beneficiaries*, The Commonwealth Fund, May 2008. Available at www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2008/May/Medicare%20Part%20D%20%20State%20and%20Local%20Efforts%20to%20Assist%20Vulnerable%20Beneficiaries/Summer_McarePartDstatelocalefforts_1126_ib%20pdf.pdf, accessed June 30, 2010.

[60] Personal communication with Maureen Dea and Anne Smith, Maine Legal Services, July 20, 2009.

[61] Medicare Rights Center, *Expanding Eligibility for Medicare Savings Programs: The Case for New York State*, December 2007. Available at www.medicarerights.org/pdf/Expanding_Eligibility_for_MSP.pdf, accessed June19, 2009.

[62] State Solutions, *Medicare Part D Implementation: Maine's Approach*, PowerPoint presentation, 2007.

[63] Maine also allows generous income disregards for MSP applicants—$55 for an individual and $80 for a married couple—effectively raising the income limits even higher. *See* State of Maine, *MaineCare Eligibility Manual*, Section 3440.04. Available at www.maine.gov/sos/cec/rules/10/144/ch332/1443323.doc, accessed on December 8, 2009.

[64] MedPAC*,* "Increasing Participation in the Medicare Savings Programs and the Low-Income Drug Subsidy," chapter 5 in *Report to the Congress*, March 2008.

[65] Medicare Rights Center, *Expanding Eligibility for Medicare Savings Programs*.

[66] Acting as the consumers' "authorized representative," the Department of Health and Human Services can also appeal Part D denials and facilitate enrollment into Part D plans. *See* 10-44, *Maine State Services Manual*, Chapter 104, Section 2. Available at www.maine.gov/dhhs/oes/hiap/c_104_s_2_4_other_f_complete.pdf, accessed on July 13, 2010.

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[68] MedPAC, "Increasing Participation in the Medicare Savings Programs and the Low-Income Drug Subsidy," chapter 5 in *Report to the Congress*, March 2008.
[69] Ibid.
[70] State of Maine, *MaineCare Eligibility Manual*, Section 3700.05. Available at www.maine.gov/sos/cec/rules/10/144/ch332/1443323.doc, accessed on December 8, 2009.
[71] According to CMS, 2,286 Medicare consumers in Maine were "un-redeemed" for LIS in 2010. *See* www.cms.hhs.gov/LimitedIncomeandResources/, accessed on March 25, 2010.
[72] Personal communication with Maureen Dea and Anne Smith, Maine Legal Services, July 20, 2009.
[73] The Center for Medicare Advocacy, Inc., *The Times They Are A-Changin': 2010 Brings Improvements to Programs for Low Income Medicare Beneficiaries*, October 1, 2009. Available at www.medicareadvocacy.org/Print/2009/MSP_09_10.01.MIPPA.htm, accessed on December 6, 2009.
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[77] Kaiser Family Foundation, *State Health Facts*. Available at www.statehealthfacts.org/profileind.jsp?ind=290&cat=6&rgn=18, accessed on March 25, 2010.
[78] Kansas Medicare Savings Coalition, Meeting Minutes, July 20, 2009.
[79] Personal communication with Kelli Verble, facilitator of the Kansas Medicare Savings Coalition, October 22, 2009.
[80] Kansas Medicare Savings Coalition, Meeting Minutes, August 19, 2009.
[81] Kansas Health Policy Authority, *Program Review of Eligibility Policy and Operations of Public Insurance Programs*, January 2009, p. 244.
[82] Medicare Improvements for Patients and Providers Act of 2008, H.R. 6331, §115 110th Cong. (2008). Available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h6331enr.txt.pdf, accessed on December 20, 2009.
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[84] Kansas Health Policy Authority and Social and Rehabilitation Services, "Application/Redetermination, Medicare Savings Programs," ES-3100.8, December 2008.
[85] State of Kansas Department of Social and Rehabilitation Services, "Economic and Employment Support. Application/Redetermination for Health Care Coverage and Food Stamps For Elderly and Persons with Disabilities (Including Medicare Savings Programs)," ES-3100.4, January 2001.
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[87] Kansas Health Policy Authority, *Program Review of Eligibility Policy and Operations of Public Insurance Programs*, January 2009, p. 241.
[88] Kansas Health Policy Authority press release, "KHPA Warns of Growing Backlog," May 1, 2009.
[89] Ibid.

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[91] Kansas Health Policy Authority press release, "Programs serving children, the elderly, and disabled are cut to balance budget," December 4, 2009. The rate of abandoned calls to the center has tripled in recent months.
[92] Personal communication with Jeanine Schieferecke aND Tim Schroeder, KHPA, April 24, 2009.
[93] Kansas Health Policy Authority, "Overview of Programs for Elder and Persons with Disabilities," January 2010. Available at www.khpa.ks.gov/healthwave/download/Fact_Sheet_Programs_Elderly_and_Persons_with_Disabilities.pdf, accessed on July 1, 2010.
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[115] Ibid.
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[117] Heflin, C. and Mueser, P., *Assessing the Impact of On-line Application on Florida's Food Stamp Caseload*. Available at http://paa2009.princeton.edu/download.aspx?submissionId=90522, accessed on January 1, 2010.
[118] Ibid.
[119] An example of a single point-of-entry system is BenefitsCheckUp, a national, customizable tool of the National Council on Aging.
[120] Personal communication with Varnette Biggs, Florida DCF, August 5, 2009.
[121] Cody, S., Sama Martin, E., and Nogales, R., *Modernization of the Food Stamp Program in Florida*, Mathematica Policy Research, Inc., February 2008. Available at www.fns.usda.gov/ora/menu/Published/SNAP/FILES/ProgramOperations/FloridaModern.pdf, accessed on July 1, 2010.
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[129] Ibid.
[130] Ibid.
[131] Personal communication with Nathan Lewis, Florida DCF, September 30, 2009.
[132] According to CMS, 28,134 Medicare consumers in Florida were "un-redeemed" for LIS in 2010. *See* www.cms.hhs.gov/LimitedIncomeandResources/, accessed on March 25, 2010.
[133] There are exceptions to the attestation system. Documentation will be requested in certain situations, including when an MSP applicant attests that his or her assets are less than $100 below the limits, when submitted information cannot be matched against state and federal databases, and when an application is incomplete. *Florida Department of Children and Families Policy Manual*, 1640.0207. Available at www.dcf.state.fl.us/publications/esspolicymanual/1630.pdf, accessed on January 2, 2010. Personal communication with Nathan Lewis, Florida DCF, September 30, 2009.

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[135] Personal communication with Miriam Harmatz and Anne Swerlick, Florida Legal Services, November 23, 2009.
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[138] Cody, S., Sama Martin, E., and Nogales, R., *Modernization of the Food Stamp Program in Florida*.
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