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Doors to Extra Help:
Boosting Enrollment in the Medicare Part D Low-Income Subsidy

by

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The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

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The Medicare Modernization Act (MMA) of 2003 established the Low-Income Subsidy (LIS) program to reduce the financial burden on low-income Medicare beneficiaries of paying out of pocket costs for prescription drug coverage under Medicare Part D. MMA requires both the Social Security Administration (SSA) and state Medicaid agencies to accept and process LIS applications. It also requires states to screen LIS applicants who apply through Medicaid agencies to determine if they are eligible for Medicare Savings Programs (MSP), which pay low-income beneficiaries' share of costs for Medicare-covered hospital and outpatient services.

This study assesses how the LIS application processes set up by SSA and state Medicaid agencies help or hinder Medicare beneficiaries who may be eligible for LIS to apply for benefits if they are not automatically enrolled as existing Medicaid or SSI beneficiaries. It also examines whether and how LIS application processes increase the potential for LIS applicants to be screened for MSP eligibility. The study defines application processes as: (1) the application forms, (2) modes for submitting the forms, (3) procedures used to inform applicants of approval or denial, (4) appeal provisions, and (4) methods for referring applicants to other programs for which they might be eligible instead of or in addition to LIS and MSP.

Methods. This study is based on semi-structured telephone and on-site interviews with federal, state, and local agencies responsible for LIS outreach, application assistance, eligibility determination, redetermination, and appeals. From October to December 2006, 47 individuals in eight states were interviewed, including staff in regional and local SSA offices, state and local Medicaid offices, state health insurance assistance programs (SHIPs) and their local branches, state pharmaceutical assistance programs (SPAPs), Area Agencies on Aging (AAAs), legal services for the elderly, and other counseling organizations. Insights and views from national experts on the LIS program and from selected state Medicaid directors supplement the findings.

What We Found

Multiple Doors to LIS. MMA established two "front doors" through which low-income Medicare beneficiaries who are potentially LIS-eligible and not already enrolled in Medicaid or Supplemental Security Income (SSI) may apply for LIS. One door is through SSA; the other is through state Medicaid agencies. By December 2006, 18 months after LIS applications could first be submitted, SSA had processed more than 5 million applications, and state Medicaid agencies appeared to have processed only a few thousand.

In addition to the two official doorways into LIS, Medicare beneficiaries who may be LIS-eligible can apply for the program through two "side" doors, both of which require the state Medicaid agency to screen applicants for MSP eligibility. Low-income beneficiaries who apply for MSP through state Medicaid agencies and are determined eligible for MSP are automatically enrolled in LIS. Those who apply for LIS through SSA but are found ineligible may undergo subsequent screening by the state for MSP eligibility and, if determined eligible, also be enrolled in LIS. While MMA intended the LIS application process to provide an opportunity to screen applicants for MSP, this study finds that the process is generally not producing the desired outcome. Relatively few people apply for the LIS through state Medicaid agencies and at the

time of the study, federal agencies were not yet providing LIS applicant information to states for MSP screening and outreach.[1]

The study shows that eligible low-income beneficiaries are able to apply and qualify for the LIS program through the door that is easier to navigate or more beneficial to them, when they are guided by the outreach and one-on-one assistance of state and community-based counseling organizations and SPAPs. These organizations are critical pathways through which many older adults and people with disabilities initiate and complete the LIS application process.

In addition, the study finds that while MMA established national eligibility rules governing the maximum income and assets that determine Medicare beneficiaries' eligibility for LIS, individuals with income and assets above the limits may or may not be determined eligible for LIS, depending on the state in which they live and the door through which they apply. As illustrated by the eight states included in the study, substantial differences in state Medicaid eligibility rules for both full Medicaid benefits and partial benefits (MSP) mean that persons in the same economic and household situations are treated differently across states. Variation among states regarding eligibility rules and standards has always been an aspect of the Medicaid program; variation has now been introduced into the Medicare program because of differences in state eligibility rules for Medicaid and MSP.

SSA and State Medicaid Agency Innovations in Application Processes. SSA designed LIS application forms and procedures to make it easy for low-income Medicare beneficiaries to apply for LIS benefits. The study finds that, in many respects, SSA's LIS application processes are simpler or more convenient for beneficiaries than state MSP application processes. In addition, SSA's LIS application process—as well as its eligibility determination, redetermination, and appeal procedures—is uniform and relatively consistent throughout the country. Therefore, eligible individuals who apply for LIS benefits are likely to be treated uniformly regardless of state of residence. This contrasts with the state-administered MSP, which is characterized by different eligibility standards and wide variation in application modes and processes.

Among the eight state Medicaid agencies examined in this study, two use their role in the LIS application process to make it easier for people to apply or qualify for both LIS and MSP at the same time. One state modified its MSP application form to allow people to apply for both programs on one form, eliminating the need for separate applications. The other state changed its MSP eligibility rules by disregarding all assets, allowing it to screen enrollees in the state's pharmaceutical assistance program for MSP eligibility. Those determined eligible are automatically enrolled in MSP and consequently deemed eligible for LIS.

These two state approaches offer useful models for other states interested in increasing the number of people who apply and qualify for both LIS and MSP cost-sharing programs. States may be reluctant to adopt such policies or procedures because MSP enrollment increases raise state Medicaid costs. But in some states, overall savings may result if the prescription drug costs of those who qualify for LIS or MSP were previously paid by state-only funds.

[1] As this study was going to print federal agencies were still not providing LIS applicant information to states for MSP screening and outreach

Barriers to LIS Enrollment. The study identifies several barriers that may prevent potentially eligible Medicare beneficiaries from learning about the LIS program, applying to the program, and obtaining help with the application. Among them are factors not specific to the LIS program, such as reluctance to disclose personal financial information to government agencies, as well as federal law or rules concerning LIS eligibility, such as disregarding only $20 of monthly income and relatively low asset limits. Application processes – the focus of this study – also present barriers to enrollment that could be reduced without changes in law or regulations. Among the most significant barriers are inadequate availability of one-on-one help in filling out the application, and insufficient information-sharing among SSA, states, and state and local counseling agencies on the status of LIS applications and potential LIS-eligibles

Further Improvements to LIS Outreach and Application and MSP Screening Processes. Although the exact number is not known, the U.S. Department of Health and Human Services (DHHS) has estimated that at least 3 million LIS-eligibles are not enrolled in LIS, accounting for about 40 percent of those estimated to be potentially LIS-eligible (DHHS 2006b). In addition, another 500,000 or more people who were automatically enrolled in LIS through Medicaid, MSP, or SSI may lose LIS benefits in 2008, as occurred in 2007; they must apply for LIS again to determine whether they qualify for LIS on the basis of federal eligibility rules.

Based on their experience in helping low-income Medicare beneficiaries apply for public benefits, study participants offer several suggestions for identifying these low-income Medicare beneficiaries and helping them apply for LIS:

- Improve SSA communication with Medicare beneficiaries who may be potentially eligible for LIS, taking care to minimize confusion and avoid overwhelming beneficiaries with information. Simpler language, greater emphasis on the difference between LIS and Part D and on the two-step application process to obtain prescription drug coverage at reduced cost, and publicity about telephone lines dedicated to LIS application assistance would encourage more Medicare beneficiaries to apply for the program.

- Strengthen state Medicaid agency involvement in both the LIS application process and MSP screening by providing more training and education to local Medicaid eligibility workers about LIS, developing data exchange agreements with SSA for obtaining LIS leads data—information about persons who apply for LIS through SSA—so that states can identify low-income persons who might qualify for MSP in addition to or instead of LIS, rather than through the Centers for Medicare and Medicaid Services (CMS), and sharing data with other state or community organizations on deemed LIS beneficiaries losing coverage in the following year.

- Establish regular communication and data-sharing agreements between SSA and SPAPs, SHIPs, and other state and local organizations that currently help people apply for the LIS program so that these third parties can submit LIS applications on behalf of Medicare beneficiaries directly to SSA and, if problems arise, receive information on the status of applications.

- Forge stronger partnerships between SSA, state Medicaid agencies, and state and local organizations that provide one-on-one assistance to Medicare beneficiaries in the LIS application process by allowing more information to be shared about potential eligibles for proactive outreach and providing contact information for SSA and CMS officials in each region responsible for Part D or LIS program issues.

I. Introduction and Purpose of the Study

A. Background on Medicare Part D Low-Income Subsidy

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) significantly enhanced Medicare benefits by adding coverage of outpatient prescription drugs under Part D, effective January 1, 2006. Equally important was MMA's provision for subsidies to Medicare beneficiaries with limited income and resources. The subsidy provision, known as the Low-Income Subsidy (LIS) and sometimes referred to as "extra help," aims to reduce the financial burden of monthly premiums and other cost sharing charged by Part D prescription drug plans. Under LIS, Medicare beneficiaries who qualify for subsidies include (1) those already enrolled in both Medicare and Medicaid as full dual eligibles or in Medicare Savings Programs (MSPs) as partial dual eligibles,[2] who are automatically deemed eligible and enrolled in LIS, and (2) those with annual income below 150 percent of the federal poverty level (FPL) and assets below specified amounts, who must submit an application to determine whether they meet eligibility requirements—hereafter referred to as potential LIS-eligibles.

Congress assigned responsibility for administering LIS to three government agencies—the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (DHHS), the Social Security Administration (SSA), and state Medicaid agencies. CMS and state Medicaid agencies have primary responsibility for transitioning full and partial dual eligibles from Medicaid into LIS and the Medicare Part D prescription drug plans. SSA has primary responsibility for accepting and processing applications from potential LIS-eligibles, although Congress also requires state Medicaid agencies to accept and process LIS applications (Table 1).

DHHS estimated that between 13.2 and 14.4 million Medicare beneficiaries would be eligible for LIS, of whom 6.3 to 7.3 million were dual eligibles or SSI recipients automatically deemed eligible for LIS without submission of an application.[3] The remaining 7 to 8 million were Medicare beneficiaries who were not deemed automatically eligible but who potentially met LIS income and asset requirements and would need to apply for the benefit. Because the program was new, projections of how many in the latter group of non-deemed eligibles would enroll in the first year of program operation varied from 2.3 to 4.6 million Medicare beneficiaries.[4]

As of November 2006, SSA reported that it had approved 2,180,746 LIS applications out of over 5 million submitted (SSA November 2006). Despite efforts to find and encourage all those eligible for LIS to apply for the benefit, estimates suggest that around 3 million potential LIS-

[2] Full dual eligibles are entitled to receive all services covered by a state's Medicaid program. Partial dual eligibles who qualify under MSP receive financial assistance to help pay for all or some Medicare Part A and Part B premiums, deductibles, and copayments. See the section entitled "How Door to LIS Differ" for details on minimum federal eligibility rules for MSP and how they compare with federal LIS eligibility rules. Individuals receiving SSI cash benefits, even if they were not also enrolled in Medicaid, were also automatically deemed eligible for LIS.

[3] DHHS released both estimates, but at different times. The lower figures were cited in DHHS 2005, and the higher figures in DHHS 2006a. The 2006 figures were based on an analysis of updated Survey of Income and Program Participation (SIPP) and Current Population Survey (CPS) data.

[4] DHHS initially projected that 4.6 non-deemed eligibles would enroll during the program's first year, and CBO estimated that 2.3 million non dual-eligibles would enroll in LIS (CBO 2004).

eligible Medicare beneficiaries are not yet enrolled (DHHS 2006b). The exact number remains uncertain because information on beneficiaries' assets is not readily available (Congressional Budget Office [CBO] 2004; Rice and Desmond 2006).

Finding and enrolling low-income Medicare beneficiaries in a program that offers financial assistance with cost sharing has proven difficult. Medicare Savings Programs (MSPs), which help low-income beneficiaries pay for Medicare cost sharing under Parts A and B (for hospital and outpatient care) and target a population similar though not identical to that eligible for LIS, have historically achieved low participation rates. Estimates indicate that about 3 in 10 eligible people participate in MSP as Qualified Medicare Beneficiaries (QMBs) and that about 1 in 8 eligible people participate in MSP as Specified Low-Income Medicare Beneficiaries (SLMBs) (CBO 2004).[5]

Given that the LIS benefit was regarded as critical to ensuring that low-income beneficiaries could afford the new Medicare prescription drug benefit, Congress designed it "with apparent attention to the lessons learned over the years about improving MSP participation" (Nemore, Bender, and Kwok 2006). For example, MMA assigned responsibility to SSA for administering LIS applications and determining the eligibility of those not automatically deemed LIS-eligible, because Congress believed that SSA was less associated with welfare than state Medicaid agencies (U.S. Congress House Committee on Ways and Means 2003, p. 162). MMA also required SSA to design a simple and easy-to-read application (Table 1).

By assigning administration of the LIS application process to a federal agency operating with consistent national eligibility rules, MMA reduces the potential for state-level variation in LIS participation rates due to different state eligibility criteria, as is the case with MSP. However, MMA still requires state Medicaid agencies to accept and process LIS applications. In addition, to help boost MSP participation rates, MMA requires states to screen LIS applicants for MSP eligibility and enroll them if they qualify. CMS also planned to make available to states information about LIS applicants who apply to SSA to help the states identify beneficiaries who may qualify for MSP (Table 1).

B. Study Purpose and Guide to Report

The purpose of this study is to assess how the LIS application processes established by SSA and state Medicaid agencies have helped or hindered Medicare beneficiaries who are potentially eligible for LIS apply for and enroll in the program. The study also examines whether and how LIS application processes increase the potential for state Medicaid agencies to screen LIS applicants for MSP eligibility. Specifically, the research seeks to answer the following questions:

- Is SSA's LIS application process simple and easy for Medicare beneficiaries to use? Do certain aspects of SSA's application process pose barriers to beneficiaries applying for and enrolling in LIS? Does SSA implement the LIS application process consistently across the country?

[5] A third component of MSP is the Qualifying Individual (QI) program; each MSP component is described in more detail below.

- How do state Medicaid agencies implement their responsibility for accepting and processing LIS applications from potential LIS-eligibles and then screening applicants for MSP eligibility? Do the systems and processes used by the agencies help or hinder Medicare beneficiaries in applying and qualifying for LIS and MSP?

- How do SSA, CMS, and state Medicaid agencies worked together to screen LIS applicants for eligibility for MSP and then enroll them if they qualify?

The study's findings are subject to some limitations. First, although we selected eight study states to illustrate different approaches to LIS enrollment and MSP screening processes across the 50 states, our conclusions do not necessarily apply to all states. Second, while outreach and public education about the LIS program are essential for locating Medicare beneficiaries who are potentially eligible for LIS and informing them about it, the study focuses on the experiences of LIS-eligibles who know about the program but may face hurdles in the application process. Third, although one of the doors to LIS is through the MSP application process, the study does not describe each state's MSP enrollment experience in detail; recent reports have covered the topic extensively (Summer and Ihara 2005; Ebeler, Van de Water, and Demchak 2006; Nemore, Bender, and Kwok 2006; Summer 2006; Rosenbach and Lamphere 1999).

The section entitled "Study Approach and Methodology" presents the study framework for examining the doors to LIS and describes the study's methods and data sources. The section entitled "How the Doors to LIS Differ" discusses the LIS application processes established by SSA and state Medicaid agencies and examines how state Medicaid eligibility rules for MSP can influence whether individuals gain automatic LIS eligibility. "Factors that Promote or Hinder Access to LIS" assesses the factors that facilitate or create barriers to LIS application and enrollment in each of the entryways and whether the LIS application process has increased the potential for low-income Medicare beneficiaries to be screened for MSP eligibility. "Making it Easier to Enter the Doors to LIS" recommends changes to policy and practice to ease some of the barriers to LIS application or enrollment among those who are potentially eligible but not yet enrolled and to make better use of the LIS application process to increase MSP enrollment.

Table 1. Federal and State Agency Responsibilities under the Medicare Modernization Act

	CMS	SSA	States
Application	CMS and SSA shall jointly develop a simplified application and process for LIS and provide the form to the states.[6]		
Eligibility Determinations		LIS-eligibility shall be determined by the SSA or by the state. When an individual applies to the state for the LIS, the state shall also determine the individual's eligibility for MSP.[7] CMS "strongly recommends" that states use the SSA application process as the default for processing LIS eligibility, although states are still required to develop a process for individuals who insist on a state determination.[8]	
Outreach		Low-income subsidy applications, information, and application assistance shall be available to beneficiaries in all SSA offices and State Medicaid offices. It is the intent of Congress that, while enrollment at SSA offices is important, both Medicaid programs and SSA should engage in outreach activities to encourage eligible individuals to apply for subsidies.[9]	
Leads Data for MSP Screening	CMS will share leads data from SSA with the states.[10]	Under section 1144 of the Social Security Act, SSA is required to identify potential MSP eligibles, notify them of the program, and send a list of potential eligibles to the states (leads data). SSA will provide high-level data on the outcome of LIS determinations with CMS, although it is unable to provide income and resource information.	According to CMS guidance, states are expected (but not required) to use leads data to screen those who have applied for LIS for MSP and help them complete an MSP application.[11]

[6] 42 U.S.C. 1395w-114

[7] 42 U.S.C. 1396u-5(a)(3)

[8] "Medicare Prescription Drug Benefit Final Rule," 70 CFR 4381 and Centers for Medicare and Medicaid Services, "Guidance to States on the Low-Income Subsidy", May 25, 2005, §10.3.3.

[9] MMA Conference Report (HR 108-391).

[10] 70 Federal Register, 4419, January 28, 2005.

[11] "Medicare Prescription Drug Benefit Final Rule," 70 CFR 4381.

II. Study Approach and Methodology

A. Study Framework

The study compares the ease with which potential LIS-eligibles can apply for LIS through the various doors into the program. Potential LIS-eligibles are individuals who are not already full or partial dual eligibles (Medicare and Medicaid) or SSI recipients and therefore must apply for LIS. The doors are distinguished by which agency (SSA or a state Medicaid office) the LIS applicant enters and the eligibility rules under which the applicant might qualify.

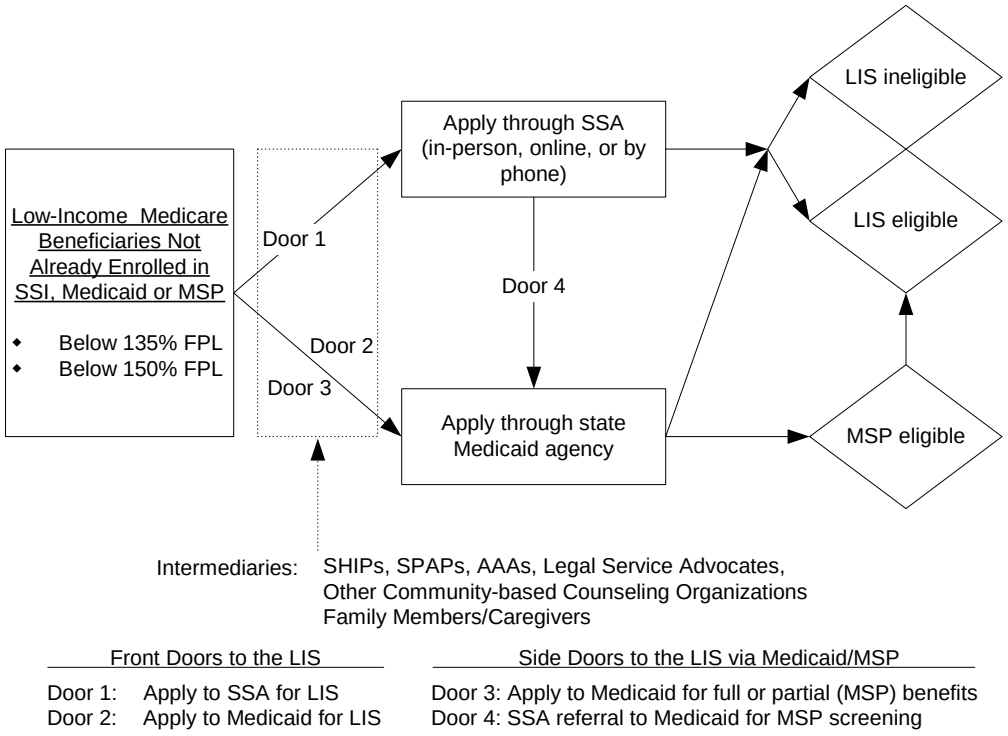
As shown in Figure 1, two "front doors" lead directly into LIS. Door Number 1 represents the SSA application process through which potential LIS-eligibles submit their LIS application using SSA's form. The MMA also requires state Medicaid agencies to accept and process LIS applications; these agencies represent Door Number 2. Entering through this door is potentially advantageous to LIS applicants because the MMA requires states to screen LIS applicants simultaneously for eligibility for MSP (administered by each state's Medicaid agencies) and to enroll them if they are determined to be eligible.

Two "side doors" indirectly lead into LIS via Medicaid agencies. Door Number 3 represents an entryway for people who are newly applying for Medicaid either as full-benefit Medicaid beneficiaries or for partial benefits under MSP. States have some flexibility in determining MSP eligibility rules, particularly whether and how they count assets; therefore, the size of Door Number 3 may differ from state to state and may allow applicants otherwise ineligible for LIS to qualify for the full LIS subsidy. In addition, each state's Medicaid application process may involve features that make it more or less difficult to complete and submit an application such as the availability of online applications; requirements for in-person interviews or supporting documentation; or lengthy and difficult application forms. States also have varying rules governing how people can qualify for Medicaid in other ways. For example, many states operate "medically needy" programs in which medical expenses reduce countable income for eligibility purposes. If a person entered through Door Number 3 and qualified for Medicaid under state eligibility rules, the applicant would automatically be deemed eligible for LIS benefits as well.

As noted above, in its final rules for implementing MMA, CMS planned to make available to states information about persons who apply directly to SSA for LIS (both approvals and denials) so that the states can identify low-income persons who might qualify for MSP in addition to or instead of LIS. The information, referred to as leads data,[12] is shown in Figure 1 as Door Number 4. This can be an important entryway into LIS for persons who are initially denied LIS eligibility under SSA rules but subsequently deemed eligible for LIS by virtue of their eligibility for MSP under a state's eligibility rules.

[12] Data elements that states are supposed to receive from CMS include: beneficiary name; whether the subsidy was approved; subsidy approval/disapproval date; LIS effective date; resources over or under LIS limit; income used for determination (individual/couple); income as percentage of the federal poverty level; denial reason (no Medicare, not in United States, failure to cooperate, resources too high, income too high); and mailing address. The leads data will not reveal specific details about individuals' assets, which would be needed to screen accurately for MSP eligibility.

Figure 1. LIS and MSP Enrollment Study Framework



Finally, a number of intermediaries can serve as pathways to the various LIS doors described above. For example, about half of all states operate state pharmaceutical assistance programs (SPAPs), most of which predate the Medicare prescription drug benefit and have been modified in response to it. SPAPs typically serve the near-poor and moderate-income population that does not qualify for Medicaid. Since the introduction of Medicare Part D, many SPAPs have revised their eligibility rules to serve those not eligible for LIS or to provide "wraparound" coverage that fills gaps in Part D coverage for those who do qualify for LIS (Fox and Schofield 2006; Williams et al. 2005). With many states requiring eligible SPAP enrollees to apply for LIS as a condition of receiving any SPAP "wraparound" benefits, SPAPs may offer another pathway to Door Number 1 or 2 if they provide assistance in completing or submitting the LIS application to SSA or the state Medicaid agency and possibly another pathway to Door Number 3 if they screen individuals for MSP eligibility. In addition, state health insurance assistance programs (SHIPs) and other community organizations provide help with completing both LIS and Medicaid applications. In some cases, family members and caregivers also help with applications.

The study examines how several factors influence the ease or difficulty of applying for LIS and MSP via the various doors described above. The study focuses on (1) variation in eligibility standards for entry points across states; (2) variation in application processes such as length or complexity of application forms, application modes, and documents or other requirements for verifying income and assets; (3) variation in notices to applicants regarding their eligibility and

the appeals process for those denied eligibility; and (4) coordination between SSA and state Medicaid agencies to screen for eligibility for LIS and MSP. The study also explores how the door through which LIS applicants enter determines the likelihood that they will be screened for and enrolled in MSP.

B. Methods and Data Sources

The study investigates states and SSA regions that take different approaches to the LIS application process and compares the ease/difficulty of LIS enrollment. Due to time and resource constraints, the study limited data collection to eight states in four SSA regions. To select the states, we developed a set of criteria designed to illustrate the diversity of approaches, eligible populations, and state-specific programs that influence LIS pathways to enrollment. The criteria include the following:

States that process LIS applications themselves and those that accept and forward them to SSA, thereby permitting a comparison of the ease or difficulty of applying for LIS through state and local Medicaid offices compared with the SSA process. After searching extensively for states that accepted and processed LIS applications, we found that only one state (Kansas) had reported decisions on more than 100 LIS applications. We therefore selected additional states in which the Medicaid director sent instructions to local eligibility offices to comply with MMA's requirements to accept LIS applications or to "screen and enroll" LIS applicants for MSP eligibility.

Geographic and socioeconomic diversity among the four SSA regions, reflecting high, average, and low percentages of low-income elderly who would likely be non–dual eligibles. To achieve the desired diversity, we examined poverty rates among the elderly in selected states in each region with high, average, and low proportions of low-income elderly relative to the national mean.

In each region and for the nation as a whole, a mix of states with different policies or programs that could affect the ease of submitting LIS applications. Policies might include SPAP requirements to apply for LIS or MSP eligibility rules that are more generous than federal LIS income or asset thresholds.[13]

Using these criteria, we selected eight states in four regions for in-depth study. Table A-1 in the Appendix shows poverty rates among the elderly, LIS application processing policies, and SPAP and MSP information for the study states.

Midwest:	Kansas, Missouri
West:	Arizona, California
South:	Alabama, Florida
Northeast:	Massachusetts, Vermont

[13] Current information on SPAPs was obtained from the National Conference of State Legislatures, 2006. Information on MSP was obtained from Ebeler et al. 2006; Nemore et al. 2006; and Summer and Ihara 2005. Additional information came from interviews with national LIS experts familiar with states' implementation of the LIS application process.

Data for the study came from 47 interviews (41 by telephone and 6 in person) with six key informant groups, between October and December 2006:

1. State Medicaid staff responsible for Medicaid eligibility policy for the elderly, blind, and disabled in six of the eight states (Arizona, Florida, Kansas, Massachusetts, Missouri, Vermont).

2. Local Medicaid or social service agencies that conduct MSP or LIS eligibility determinations in five of the eight states (Arizona, California, Kansas, Massachusetts, Missouri).

3. Staff of state or local branches of SHIPs in all eight states

4. SPAP staff in the three states with active programs at the time of our study (Massachusetts, Missouri, Vermont).

5. Managers or counselors in community-based organizations involved in LIS or MSP outreach, education, or client advocacy, such as Area Agencies on Aging (AAAs), legal services for the elderly, and Access to Benefits Coalition (ABCs). One to three such organizations were interviewed in each study state.

6. Regional or local SSA staff involved in LIS outreach, education, and beneficiary assistance in all eight states. Nine SSA staff members were interviewed.

Semi-structured interview guides were developed for each key informant group. Table A-2 in the Appendix presents the issues and questions explored with each group.

III. How the Doors to LIS Differ

The several routes by which eligible beneficiaries can enroll in the LIS program offer applicants relative advantages or disadvantages depending on their economic circumstances. Although MMA established uniform national eligibility rules governing income and asset limits for the Part D LIS program, Medicare beneficiaries with identical income and assets can still receive different LIS eligibility determinations if they apply for full Medicaid benefits or MSP through their state Medicaid agency or, in some states, through SPAPs.

This section describes the eligibility rules and application processes for each of the doors into LIS. Section A compares the federal LIS and state Medicaid and MSP eligibility rules in the eight states examined in the study in order to show how people in some states may qualify for LIS if they qualify for Medicaid (either full Medicaid benefits or partial benefits under MSP) even if their income or resources exceed federal LIS standards. Section B describes the LIS application process established by SSA and identifies how the process assists or impedes people in learning about and applying for benefits. Section C describes the application processes set up by state Medicaid agencies for LIS and MSP, and how these agencies make it easy or difficult for people to apply for and enroll in either program. Section D describes other ways in which people in some states can obtain help in finding their way to the most beneficial LIS door—for example, through a SPAP.

The study shows that substantial differences across states regarding eligibility rules for full or partial Medicaid benefits result in differential treatment of persons in the same economic circumstances for purposes of LIS eligibility. While such variation has always been a feature of the Medicaid program, it carries over into the Medicare LIS program because of the link between eligibility for Medicaid *and* LIS. At the same time, certain features of the application process can help overcome difficulties faced by low-income persons in navigating their way through a complicated set of agencies, forms, and procedures.

A. Door Number 1 and Door Number 3–Different Eligibility Rules for LIS and MSP Applicants

Medicare beneficiaries who are eligible for LIS may qualify under either federal LIS eligibility rules or state Medicaid eligibility rules; those who qualify for Medicaid (whether full Medicaid benefits or partial Medicaid benefits under MSP) through their state Medicaid agency (Door Number 3) are automatically deemed eligible for and enrolled in LIS.[14] Understanding the differences among the eligibility rules is important because states with more liberal income or asset rules for Medicaid than LIS can offer a more generous route to LIS enrollment than applying to SSA.

MSP Eligibility Rules. Federal rules differ with respect to the amount of income and assets that allow an individual to qualify for LIS, MSP, and Supplemental Security Income (SSI recipients also qualify automatically for LIS) (see Table 2). Although federal rules set the income and

[14] Note that MSP includes the groups Qualified Medicare Beneficiary (QMB)-only and Specified Low-Income Medicare Beneficiary (SLMB)-only. Persons who meet the federal MSP rules as well as state requirements for full Medicaid coverage are often referred to as QMB-plus and SLMB-plus; these groups receive full Medicaid benefits in addition to payments of Medicare cost sharing and/or premiums.

asset limits for MSP, states may disregard different forms of income and assets and thus may vary widely in what they count as income and assets for determining MSP eligibility (Nemore et al. 2006). The major differences between LIS and MSP are as follows:

Asset limits. LIS asset limits ($10,210 for individuals, $20,410 for couples in 2007 with another $1,500 per person allowed for burial expenses) are higher than those for MSP ($4,000 and $6,000, respectively). But the flexibility in asset counting methods accorded states by federal MSP rules means that three study states—Alabama, Arizona, Vermont—do not have asset limits for their MSPs, which they achieve by disregarding all assets. Vermont eliminated its asset test at the time of Medicare Part D implementation, intending both to make more people eligible for MSP (and thus LIS) and to align MSP eligibility rules with its SPAP (discussed further below). Arizona and Alabama had both eliminated the MSP asset test before the introduction of Part D. Respondents in Alabama note that the state eliminated the test because only a few income-eligible applicants exceeded the asset limits so the test was not worth the associated administrative costs.

Income limits. LIS income eligibility goes up to 150 percent of the federal poverty level (FPL) while MSP income eligibility stops at 135 percent of FPL. However, MSP regulations permit states to use less restrictive income and asset limits by adopting different methodologies (described in Table A-3 in the Appendix) while LIS rules give states no such flexibility. All study states use federal income limits for MSP, although some use more liberal income disregards.[15] Most non-study states disregard $20 per month in income, but the District of Columbia disregards $418 per month and Connecticut $183 per month.

In-kind support. LIS counts the value of in-kind support and maintenance as part of a beneficiary's income: 4 of the 8 study states (Alabama, Arizona, Florida, and Kansas, along with 14 other states) disregard such support for MSP income eligibility determination.

Entitlement. LIS and two of the three MSP programs—Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB)—are entitlement programs; that is, all persons who apply and qualify must be enrolled. The Qualifying Individual (QI) program, however, limits federal funding and allows states to cap total enrollment and is, therefore, not an entitlement. The federal government sets an annual funding cap such that each state can serve only as many people as permitted by its allotted funds.

Full Medicaid Eligibility Rules. In addition to state variation in MSP eligibility rules, states have different rules governing eligibility for full Medicaid benefits. SSI recipients are automatically eligible for full Medicaid benefits in most states,[16] but states may go beyond federal eligibility limits by offering Medicaid to SSI beneficiaries who receive state supplemental payments (SSP) or to all aged and disabled persons with incomes up to 100 percent

[15] To our knowledge, the District of Columbia is the only jurisdiction that has raised the income disregard to ensure that anyone eligible for LIS would also be eligible for MSP (Partridge 2006).

[16] See www.nasmd.org/eligibility/mandatory.asp for more detail on Medicaid eligibility.

of FPL, as is the case in California, Massachusetts, and Missouri.[17] In addition, income disregards in some states effectively raise income limits. Asset limits also vary across the states; six of the eight study states use the federal SSI asset limits of $2,000 for individuals and $3,000 for couples, while Florida uses higher limits ($5,000 and $6,000, respectively) and Missouri uses lower limits ($1,000 and $2,000, respectively).

The Medically Needy (MN) coverage option is another potentially important way to establish LIS eligibility. This program permits persons who would not otherwise qualify for Medicaid to deduct their medical expenses from their gross income in order to "spend down" to Medically Needy Income Limits (MNIL).[18] Even if someone qualifies for MN coverage for only one month during a year, that person is deemed eligible for LIS for the entire year.

Three of the eight study states (Alabama, Arizona, and Missouri) do not offer a MN program.[19] In the other five states the MNIL ranges from 25 percent of FPL (for singles and couples) in Florida to 100 percent or higher in Massachusetts and Vermont. Even though Florida has a relatively low MNIL, it uses a one-month budget period so people can apply accumulated medical bills in one month to qualify for the MN program and be determined eligible for an entire year of LIS. California also uses a one-month budget period while Kansas, Massachusetts, and Vermont use a six-month period for noninstitutionalized persons. Study respondents in Florida note that the MN program is especially important for persons who qualified for Medicaid eligibility via MN spend down, thereby permitting LIS eligibility in 2006. Such persons, however, could have lost LIS eligibility in 2007 unless they were again determined eligible for Medicaid MN based on incurred medical expenses during the first month or two of 2007.

In sum, the differences between the federal LIS eligibility rules and the Medicaid or MSP eligibility rules established by each state mean that, depending on the door through which a low-income Medicare beneficiary applies for assistance with Medicare cost sharing, people with the same economic and household conditions may qualify for LIS in some states but not in others.

[17] This is known as the "poverty-related coverage group" as authorized in the federal law OBRA 86. A full explanation of Medicaid eligibility rules is beyond the scope of this report. For more detail, see the National Association of State Medicaid Directors Web site at www.nasmd.org/eligibility/default.asp.

[18] To establish spend down, beneficiaries must incur medical expenses that, when deducted from their income, meet state requirements for a specified budget period ranging from one to six months. For more information, see www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14325.

[19] Since Missouri is a 209(b) state, it must permit people to spend down to the SSI limit. The state tightened its spend-down requirements in 2005 (see Table A-3 in the Appendix for details).

Table 2. Federal Eligibility Rules for Part D Low-Income Subsidy, Medicare Savings Programs, and Supplemental Security Income[1]

Program	Income Limit	Asset Limits (Individual/Couple)	Covered Costs and Benefits (2006)
Medicare Part D Low-Income Subsidy			
Part D LIS Full Subsidy	Below 135% FPL[2]	$6,120/$9,190[3]	Federal government pays monthly premiums and deductible; waives copayments of $1 to $2 for generic drugs and $3 to $5 for brand-name drugs after total spending of $5,100
Part D LIS Partial Subsidy	135–150% FPL[2]	$10,210/$20,410[3]	Federal government pays monthly premium on a sliding scale up to $27.35, annual deductible costs over $50, and 85% of total costs up to $5,100
Medicare Savings Program (MSP)			
Qualified Medicare Beneficiary (QMB)	Below 100% FPL	$4,000/$6,000	State Medicaid program pays Medicare Part B (and Part A if needed) premiums, deductibles, and other Medicare cost sharing[4]
Specified Low-Income Medicare Beneficiary (SLMB)	Below 120% FPL	$4,000/$6,000	State Medicaid program pays Medicare Part B monthly premiums only
Qualifying Individual (QI)	Below 135% FPL	$4,000/$6,000	State Medicaid program pays Medicare Part B monthly premiums only; participants limited to the number who may be served up to annual federal spending cap
Supplemental Security Income (SSI)			
Full SSI	Below 74% FPL[5]	$2,000/$3,000[5]	State Medicaid program provides full Medicaid benefits and pays Medicare premiums and cost sharing

Notes:
[1] Eligibility rules in Table 2 were in effect 2007. Alaska and Hawaii use qualifying income limits that may differ from those of other states.
[2] The 2007 federal poverty level is $10,210 for an individual and $13,690 for a couple (excluding a $20 monthly disregard).
[3] An additional $1,500 for an individual and $3,000 for a couple are permitted for funeral or burial expenses.
[4] Medicare Part B premiums are $93.50 per month in 2007, and the annual Part B deductible is $131 (CMS press release, September 12, 2006).
[5] Countable income excludes a $20 monthly disregard, $65 per month of earned income plus half of remaining earnings, and public benefits such as food stamps and housing assistance. Countable assets exclude homes, cars, burial funds, and cash surrender value of life insurance. Eleven states, known as 209(b) states, are allowed to use income or resource standards that are more restrictive than federal rules. As of 2001, 28 states also provided state supplemental payments (SSP), which are additional cash payments to people with incomes above SSI income limits (but not resource limits).

B. Front Door: SSA's LIS Application Processes

In July 2005, SSA began accepting LIS applications and making eligibility determinations prior to the start of the Medicare Part D program in January 2006. The following summarizes the methods used by SSA during 2005 and 2006 to accept LIS applications, determine eligibility, adjudicate appeals, and redetermine eligibility, in accordance with final rules published at the end of 2005.[20] The discussion includes study respondents' views on how the procedures helped or hindered Medicare beneficiaries' enrollment in the LIS program.

1. Application Forms, Modes, and Eligibility Determination

SSA offers several methods for submitting LIS applications: (1) **by mail**, using the SSA-1020-OCR form, which is SSA's scannable paper application form;[21] (2) **online** via the i1020, the online version of the LIS application on SSA's Web site;[22] (3) **in-person** at SSA offices; or (4) **by telephone** using SSA's 1-800 number. Of these application modes, the most popular during the study period was to mail a hard-copy of the application. In the program's first year, four of five LIS applications arrived by mail at the Wilkes-Barre Data Operations Center (WBDOC), where LIS applications are scanned and processed.[23]

Applying by mail or online

The LIS application form is widely available; people can call to request that an application form be mailed to them, pick up one in local Social Security offices or obtain one at an outreach event. For people whose primary language is not English, the paper application is also available in Spanish. Instructions for completing the English-language application are available in 15 languages. Completed applications are processed at WBDOC, where any inconsistent, illegible, or incomplete answers generate a telephone inquiry to the applicant. If attempts to contact the applicant by phone are unsuccessful, WBDOC staff send a written follow-up request for information to the applicant or refer the case to local SSA field office staff for follow-up.

Applying in-person

SSA staff speaking with applicants in person or by phone enter information directly into SSA's computerized Intranet electronic eligibility determination system called Medicare Application

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[20] *Federal Register*. December 30, 2005, Part V, Social Security Administration, 20 CFR Part 418, Medicare Part D Subsidies; Final Rule.

[21] LIS applicants do not need to submit documents to verify income and resources because MMA permits SSA to check Internal Revenue Service (IRS) records to validate certain income information provided by LIS applicants.

[22] Social Security Administration, Program Operations Manual System, POMS HI03010.010. The Internet application (i1020) is an interactive self-help form that elicits the same information as the MAPS screens and the scannable paper application. Currently, the i1020 is available only in English and can be accessed via www.socialsecurity.gov/prescriptionhelp. For the LIS application to be processed online, it must be complete and free of any error messages and outstanding questions. SSA field office staff and staff from SSA's Immediate Claims Taking Unit (ICTU) complete and process online LIS applications using MAPS.

[23] SSA officials, meeting with older adult and disability advocates, June 1, 2006, SSA offices, Washington, DC.

Processing System (MAPS). People who call SSA's 1-800 number and speak a language other than English are connected to SSA's language line.

Ease/Difficulty of SSA LIS Application Processes and Modes. SSA has standardized and centralized most steps in the LIS application process, so there is generally little variation in how the process works in different parts of the country. All SSA staff interviewed for the study reported that local field offices were staffed with additional personnel to handle the temporary increase in the volume of requests for LIS application assistance. Most study respondents from all types of organizations believed that the additional staffing was important for beneficiaries who seek help in local SSA offices. Some respondents reported that the availability of local SSA staff to help LIS applicants is important because SSA staff may provide more personalized assistance than teleservice staff. SSA field offices also employ many bilingual staff, can deploy staff to make home visits to homebound individuals, and are experienced in helping people with various disabilities apply for other programs, such as SSI and Social Security Disability Insurance (SSDI).

Nonetheless, many study respondents (though no SSA staff) reported long lines at crowded SSA field offices or difficulty getting through on local field office telephone lines. For example, one benefits counselor pointed to the occasional long wait to reach someone by telephone at a local field office and noted that sometimes the person answering the telephone lacked complete information. Several respondents reported that SSA field offices were overwhelmed by people seeking services other than LIS, although the level of demand for services varies with the demographic makeup of the area served by the field office. Even in the same region, respondents reported that field offices' responsiveness varied, depending on each office's staffing level. While it is impossible to know how many potential LIS applicants are deterred by long waits at SSA field offices and thus do not apply or seek assistance elsewhere, it may be important to increase staffing levels in SSA offices serving areas with a large population of low-income Medicare beneficiaries.

Perhaps because they recognize that SSA field office staff cannot always provide the help needed by LIS applicants, SSA officials encourage LIS applicants, or those helping them, to fill out the application and file it online. Online filing is more likely than a paper filing to result in an accurate application as the online system detects missing or incorrect information before the application is submitted. Without the need to scan data, the online system also permits faster eligibility determination—within a week. Even so, most elderly persons prefer to mail their applications, perhaps because they are not comfortable using computers or lack Internet access.

According to several study respondents, processing times for LIS applications were longer during peak application periods, such as at the end of 2005 just before the Medicare prescription drug benefit's effective date and in May 2006 (the deadline for enrolling in a prescription drug plan without penalty).[24]

[24] CMS announced in April 2006 that those determined eligible for LIS would not incur a premium penalty for enrolling after May 15, 2006. However, because beneficiaries applying for LIS did not know whether they would be determined eligible, many applied for LIS before May 15 to avoid the penalty in case they did not qualify for LIS.

SSA field office staff interviewed for this study cite the following as the most common difficulties faced by LIS applicants: (1) although the form used in 2005 did not require applicants to report Social Security benefits, many applicants did so in various places, resulting in excess income being reported (the application form used in 2006 now has a space for inserting the benefit amount); (2) confusion about face versus cash value of life insurance; and (3) failure to understand what counts as assets.

2. Pre-Decisional Notices and Appeals

SSA established a process for the LIS program that it had not used in any previous programs. If LIS applicants fail to submit all required information on the application or the information on the application is inconsistent, SSA issues a letter called a "pre-decisional notice." The letter informs applicants that their application may be denied on the basis of the information provided (or still missing) and advises them to contact SSA to provide or clarify the information before SSA makes a final determination. If the applicant does not respond to the pre-decisional notice, SSA staff in Wilkes-Barre call him or her to obtain the needed information or they may transfer the case to the local SSA field office, which contacts the applicant for the missing information.

If the person does not respond to the pre-decisional notice within 20 days, SSA sends a *pre-denial* notice. The individual's failure to respond in a timely manner to the pre-denial notice results in the issuance of a formal denial notice with appeal rights. Applicants then have 60 days to contest or appeal a decision at an SSA office, by telephone, or by mail. The applicant may ask for either a case file review, which does not require an in-person hearing, or a telephone hearing. Case file reviews allow SSA staff to correct simple mistakes without contacting the applicant. During a telephone hearing, the applicant and special appeals staff review the application information together by phone.

SSA officials report that appeals by those declared ineligible for LIS totaled about 3 percent (75,000) of the 2.5 million applications denied in the program's first year; appeals of partial subsidy rather than full subsidy determinations added another 2.6 percent. The rate is relatively low, according to SSA, because the agency was able to convert about 62,000 applicants from a probable denial to an approval based on information provided in response to pre-decisional notice. Most applicants who appealed had not acted on the pre-decisional notice. In summer and early fall 2005, appeals typically required 30 to 45 days for adjudication. During the period of the highest volume of appeals in the first half of 2006, SSA sometimes took between 85 and 90 days to adjudicate appeals, but by fall 2006 the time was back down to 30 to 45 days.

Reasons for LIS Appeals. Because people who submitted LIS applications in 2005 were asked to prospectively estimate their earnings and assets as of January 2006, they were more likely than 2006 applicants to have to submit corrected information. Overall, about two-thirds of the appeals were based on income errors, such as income amounts entered incorrectly on the application, a change in income due to employment that ended after submission of the application, or a change in household composition. About a quarter of the appeals were based on resources entered incorrectly, a statement of resources that reflected household rather than individual assets, or a statement of resources based on bank accounts that had since been depleted. The remaining appeals involved other issues such as incorrect reporting of income support; couples who were no longer living together due to death, divorce, or institutionalization

of one spouse; or a change in residence from Puerto Rico to the continental United States.[25] Just over half of the appeals resulted in an approved LIS application; the rest were rejected or dismissed when, for example, the applicant withdrew the appeal.

Few of the study respondents were familiar with the appeals process, probably because of the relatively low number of appeals filed. Those who were familiar with it reported a range of experiences, from rapid and easy-to-understand procedures and decisions to long (over three months) and confusing processes. Respondents were not sure whether the ease or difficulty of the appeal cases they knew about was attributable to the issues involved in the beneficiary's situation or to SSA's appeal processes.

3. LIS Redetermination

MMA requires persons who qualify for LIS through SSA to undergo eligibility redetermination at least once annually.[26] It is important to assess how straightforward the redetermination process is, as redetermination ensures the uninterrupted continuation of beneficiaries' drug coverage subsidies.

SSA began the redetermination process in fall 2006 for participants who became eligible for LIS between January and April 2006, including those who applied in 2005 and first became eligible in January 2006.[27] SSA sends beneficiaries a letter summarizing the information that individuals provided in their approved LIS applications and asks about any change in income (except for annual Social Security cost-of-living adjustments), resources, or household size that would alter either their eligibility for LIS or the subsidy amount they receive. If there are no changes, the person need not take any action; SSA assumes that no response means there has not been any change in the person's circumstances. If there are changes, the person must respond by mail to SSA within 15 days; SSA then sends another form requiring the person to report changes within 30 days. SSA terminates the subsidy of those who miss the 30-day deadline effective the following January, although beneficiaries may request the local SSA field office to extend the 30-day period. Assistance in completing the form is available through SSA's toll-free teleservice call centers, which refer callers to SSA claims takers.

An eligibility redetermination is also required when a person experiences a "subsidy-changing event" such as marriage; death of a spouse; divorce, separation, or annulment of marriage; or resumption of living with a previously separated spouse. Such events may be reported at any time or at the time of the normally scheduled redetermination; in either case, the LIS enrollee must fill out a separate form to report the subsidy-changing event.

When this study was conducted in fall 2006, SSA had just instituted the redetermination process. As a result, few study respondents had experience with beneficiaries calling to request help or

[25] Puerto Rico has a separate subsidy program in which SSA is not involved. Residents of Puerto Rico who move to the continental United States are eligible to apply for LIS, however.

[26] SSA Program Operations Manual System (POMS), HI 03050.010 Redeterminations of Eligibility.

[27] SSA excludes from redetermination those who become *deemed* LIS eligibles, that is, those who qualify for full Medicaid benefits or for the state's MSP. Individuals whose eligibility started in May 2006 or later are not required to undergo eligibility redetermination until August 2007. SSA has not yet decided on the intervals for subsequent redetermination of LIS eligibility (i.e., annually or possibly less frequently).

clarification. Those who had received inquiries said that many called because they did not know that they would have to undergo a redetermination review. The letter of approval for initial LIS applicants did not make it clear that a redetermination review would occur; thus, redetermination requirements confused or surprised some beneficiaries.

C. The Doors to LIS through State Medicaid Agencies

In addition to SSA as a door to LIS, state Medicaid agencies offer several doors to LIS enrollment (see Figure 2). First, Medicare beneficiaries can apply directly for LIS at the Medicaid agency—Door Number 2 in the study framework. Second, beneficiaries can apply for either full Medicaid benefits or partial Medicaid benefits through MSP—Door Number 3 in the study framework. Those determined to be Medicaid- or MSP-eligible are automatically deemed eligible for LIS. Third, SSA provides CMS with information about Medicare beneficiaries who apply for LIS through SSA; the information, called "leads data," will be shared with states in order to conduct outreach to beneficiaries denied the LIS through SSA's application process but who may still qualify through enrollment in the MSP program—Door Number 4 in the study framework.

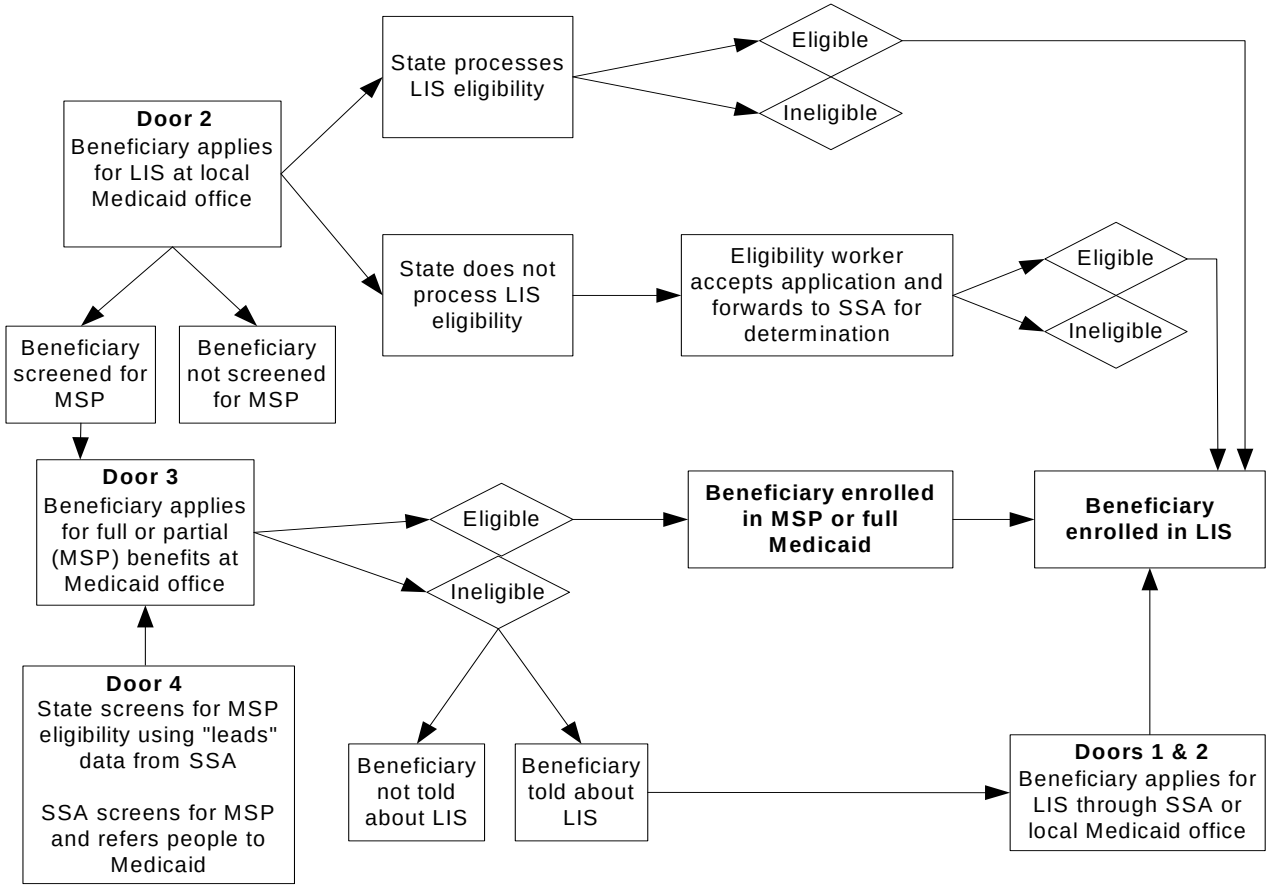
Applicants using Door Number 2 may apply for LIS by following various routes. Medicaid agencies rely on a variety of application policies and procedures across the states for each of these LIS enrollment routes; these policies and procedures affect the degree of ease or difficulty with which beneficiaries gain access to LIS. Whether LIS applicants are also screened for MSP depends on states' receipt of LIS applicant data from federal agencies and their use of the data to conduct MSP outreach and screening. The rest of this section describes how the eight study states designed their LIS application and MSP screening processes and how they made it easy or difficult for Medicare beneficiaries to apply for LIS directly or to qualify indirectly through MSP.

1. Applying for LIS through State Medicaid Agencies

MMA requires states to create a process for determining eligibility for applicants who apply for LIS at a Medicaid office. In May 2005, CMS issued guidance to states on LIS, encouraging them to guide Medicare beneficiaries into the SSA application process rather than the state's processes.[28] In fact, SSA trained state Medicaid agency staff in the use of the SSA application, created a compact disc with the training materials, and posted guidance on its Web site. If an applicant wants to use the SSA form, the state may help the applicant complete it and submit the completed form to SSA's Wilkes-Barre Data Operations Center.

[28] CMS, "Guidance to States on the Low-Income Subsidy," May 25, 2005; CMS, "State Medicaid Agencies Medicare Modernization Act—Final Rule," *Fact Sheet*. www.cms.hhs.gov/States/Downloads/GuidancetoStatesonLimited-IncomeSubsidy.pdf

Figure 2. State Medicaid Agency Routes to LIS



If an applicant specifically asks a state to determine his or her LIS eligibility, the state must do so, according to CMS guidance.[29] States are required to create their own application process, which might include manual determination of eligibility based on the SSA application, development of new state LIS application forms and eligibility determination processes, or modification of an existing application, such as that for MSP, as long as the application captures all items needed for LIS determination. While states are required to use the LIS rules for determining eligibility, those that develop their own LIS forms may require applicants to submit documents to verify income and assets just as they do for MSP, since states making an LIS eligibility determination would not have access to IRS income data as SSA does when it makes eligibility determinations. States that determine LIS eligibility must also issue notices regarding approval, denial, termination, and changes and must process appeals, interim changes, and redeterminations.

[29] States were advised to ask applicants if they had already applied for LIS through SSA and if so, to recommend that they wait for a determination. However, if the beneficiary still wants to apply for LIS through the state Medicaid agency, the state must make an eligibility determination using its own process.

Kansas's Combined LIS/MSP Application Form. Of the eight study states, only Kansas has developed its own LIS application and has processed eligibility for the program.[30] A state official explained that Kansas created the form following enactment of MMA to encourage people with high drug costs to apply for MSP so they would be deemed LIS-eligible when the drug benefit took effect in January 2006. Concurrently in 2005, Kansas decided to develop a "short application" for MSP, similar to that already used by many other states. When Kansas officials learned that MMA requires state Medicaid agencies to accept LIS applications, they decided to combine the MSP and LIS applications into a single form but did not add the option to apply for LIS to the state's "long application," which screens for full Medicaid and other benefits.

As of January 2006, about 1,400 Kansas beneficiaries had used the combined MSP/LIS application to apply for assistance. Study respondents in Kansas cited a number of reasons that the revised MSP/LIS application did not generate more LIS applications. Unlike the SSA application process, an applicant must visit a local social service office to apply for LIS and provide documentation about income and assets (consistent with CMS guidance to states). As a result, someone who is interested in applying *only* for LIS is usually referred to SSA. In addition, local social services staff usually encourage applicants to fill out the longer application, which screens for full Medicaid and other public benefits such as food stamps but does not screen for LIS. Further, many community-based counseling staff in AAAs and legal service agencies are unaware of the revised MSP/LIS application form. Study respondents also note that the state's history of strong estate recovery practices for those in other Medicaid program categories might deter people from applying to MSP.

Other States' LIS Application Policies. Study respondents in Medicaid agencies in the seven other study states do not regard LIS eligibility processing as a high priority. Respondents note that they lack the resources required to process eligibility and that SSA or CMS had encouraged them to use the SSA process. Some also stated that they do not want to be responsible for LIS redeterminations and appeals for beneficiaries whose eligibility they have processed. Nonetheless, most study states say that, if an applicant were to insist, they would be prepared to process LIS eligibility manually with the SSA form or would recreate the SSA form with the state's name on it. State Medicaid eligibility officials in California, Florida, and Massachusetts have issued written guidance to local intake staff about how to make eligibility determinations, but study respondents were unaware of any LIS determinations by the state.

State LIS Application Assistance. Respondents in the eight study states reported differences in the type or amount of assistance they were prepared to provide to LIS applicants who visit Medicaid offices. In some study states, local and state Medicaid agency respondents said that, sometimes because of lack of training, they are not familiar with the SSA application; consequently, eligibility workers offer basic information about the LIS program but refer people to SSA or to a SHIP for assistance in completing an application. One local Medicaid office reported that when people inquire about the LIS program office staff refer them to Medicare (via 1-800-MEDICARE). Another state either directs applicants to a computer terminal to apply to SSA online or provides them with a paper LIS application if they do not have all the needed information. One state instructs its eligibility workers not to conduct any outreach or answer any

[30] As far as we know, only one other state—Colorado—has processed a significant number of LIS applications.

questions about LIS; instead workers are instructed to refer people to SSA. Another state reportedly directs its caseworkers to tell people requesting a state LIS determination that the determination would require a couple of months. Because of variation in knowledge about and commitment to the LIS program, study respondents reported that state Medicaid staff do not always tell Medicaid and MSP applicants who are determined to be ineligible for those programs about LIS as an alternative source of assistance with Medicare cost sharing.

2. State MSP Application and Screening Policies and Processes

Depending on the policies and practices used by states to accept MSP applications or to screen and enroll potential MSP-eligibles into the program, MSP may or may not provide effective entry into LIS. For example, Summer and Ihara (2005) note some features that make it easier for MSP-eligible individuals to apply, including short applications (six of the eight study states) and the option to mail applications (all eight study states). Florida is the only state among the eight study states that makes online MSP applications available as part of its "modernization" initiative;[31] the online process is reportedly Florida's predominant mode of application for MSP. As with LIS, five of the eight states—Alabama, Arizona, Florida, Massachusetts, and Vermont—allow MSP applicants to self-declare income or assets without providing documentation (Nemore et al. 2006).[32]

State MSP Screening of LIS Applicants. Because few people apply for LIS through state Medicaid agencies, the agencies provide little screening for MSP. Many state and local Medicaid agency staff said that they encourage applicants who inquire about LIS (or any other type of assistance) to complete the full Medicaid application to ensure that they receive the full range of benefits for which they qualify. Other agency staff said that Medicaid offices always screen those interested in applying for assistance with Medicare cost sharing for MSP; if applicants do not want to apply for MSP, staff still give them an LIS application. However, some respondents, including Medicaid staff, were not sure whether LIS applicants are always screened for MSP. In one state, respondents voiced frustration that, in the absence of MSP screening, applicants who mention Part D or LIS to Medicaid workers are referred to the SHIP, and when the SHIP screens for MSP it often refers applicants back to Medicaid.

State-Facilitated Enrollment into MSP. Some states with SPAPs require or encourage their SPAP members to apply for LIS to relieve the state of the burden of prescription drug coverage for LIS-eligibles. Three of the eight study states operated a SPAP during 2006. One of those states—Vermont—eliminated the asset test for MSP effective January 2006. This change in policy allows the state to automatically enroll its SPAP (called VPharm) members in MSP if they meet the state's income requirements; those persons are then automatically eligible for LIS. Both the policy change and the facilitated enrollment into MSP played a major role in boosting Vermont's MSP and LIS enrollment—according to a state official, nearly 2000 people were added to the MSP QI program in the first quarter of 2006 (Hogan 2007).

[31] Since 2003, Florida has been moving to a system in which applicants for Medicaid, food stamps, and other cash benefits apply for benefits online via computers located in state and local offices or via any computer with an Internet connection. Community organizations can assist with the application process.

[32] Alabama and Arizona allow self-declaration of assets, but neither state imposes an asset limit for MSP. After reviewing an application, Massachusetts may require an applicant to submit documentation.

3. MSP Screening of LIS Applicants with Leads Data or Referrals from SSA

When this study was conducted in fall 2006, none of the study states had received LIS leads data from SSA or CMS for MSP screening purposes.[33] The data, which include limited income information, could be useful to the three study states that do not have asset limits for MSP—Alabama, Arizona, and Vermont—as person who are not eligible for LIS on the basis of assets might still be eligible for MSP as long as their income falls below the states' limits.

State officials in Arizona and Vermont and study respondents representing advocacy groups in California believe that the leads data will be useful and are interested in obtaining the information. Other state respondents, however, said that even if they did receive the data, they lack the resources to conduct additional MSP outreach or would need to determine whether they should invest resources in such outreach. Some respondents did not think the leads data would contain enough information to screen for MSP eligibility, and that it would be useful only for outreach. A few state respondents thought the leads data would not be sufficiently reliable for use in either outreach or screening.

Some state Medicaid officials do not regard MSP as a high priority for outreach and are concerned that outreach would increase the number of beneficiaries eligible for full Medicaid benefits, thereby increasing Medicaid program expenditures and "clawback" payments.[34] States would also incur additional costs as a consequence of increased MSP enrollment because Medicaid must cover the costs of Medicare premiums and cost sharing for MSP enrollees.

SSA Screening and Referral of LIS Applicants for MSP. Another potential opportunity for SSA to screen low-income Medicare beneficiaries for MSP is during the LIS application process at a local SSA field office. When asked about this opportunity, several SSA respondents reported that SSA workers are trained to screen people for several programs, including MSP. Most SSA respondents said that local SSA offices were performing MSP screening and referral before the advent of the LIS program and that the introduction of the program probably has not resulted in any change in practice. In one state with no asset limit for MSP, a SSA public affairs specialist responsible for LIS outreach stressed the importance of MSP referrals, particularly when assets would otherwise make people ineligible for LIS. In that state, when SSA participates in Part D and LIS community outreach events, SSA screens people first for LIS; if they do not qualify for LIS, local Medicaid staff or other community organizations screen them for MSP. SSA staff do not directly screen or counsel people for MSP but do partner with AAAs and local SHIP counselors at outreach events. Another respondent reported that people who appear to be eligible for MSP are referred to the state's SHIP rather than to the Medicaid office, because SHIP is primarily responsible for MSP outreach.

[33] Missouri Medicaid representatives reported that they receive a monthly file from SSA with information on *newly eligible* Medicare beneficiaries who are potentially eligible for MSP based on their Social Security income. The state sends letters to these beneficiaries about MSP and includes the local Medicaid office's telephone number.

[34] The clawback—a monthly payment made by states to the federal government to help fund Part D—is based on the number of full-benefit dual eligibles enrolled in Medicaid and does not include MSP enrollees.

D. Help Finding the Right Door into LIS and MSP

It can be difficult for potentially eligible persons to identify the best door—SSA or the state Medicaid agency—through which to apply for LIS, Medicaid, or MSP. The differences in eligibility rules between LIS and each state's MSP and Medicaid program may mean that an applicant might qualify for LIS through one route but not through another.

Study respondents cited several examples of the role of state and local counseling organizations in helping beneficiaries learn about and apply for LIS and MSP, and helping them identify the best door through which to apply for benefits. For example, one study respondent at a legal services organization counseled a couple whose income was too high to qualify them for LIS through the SSA application process. In view of the couple's significant medical expenses, the respondent advised them to apply for Medicaid through the local social services office. When the couple met the state's MN spend-down requirement, they were automatically enrolled in LIS just as they were about to hit the Medicare Part D "donut hole."[35] Study respondents explained how, in some cases, SPAPs can encourage and facilitate applying for LIS, which may cover additional prescription drug costs for members that the SPAP do not cover. The following discussion describes two pathways to the right door into LIS or MSP.

1. State and Community-Based Counseling Organizations

LIS Education and Application Assistance. According to study respondents, SHIPs and community-based organizations such as AAAs, Access to Benefits Coalitions (ABCs), and legal service organizations play a key role in educating potential LIS-eligibles about both LIS and MSP. SSA respondents said that SHIPs in particular play a pivotal role in outreach and enrollment assistance for LIS. They have been instrumental in locating the LIS-eligible population—a population with which SSA does not always have regular contact. At many events, SHIPs and other community organizations provide information about the LIS program and Part D benefits and plans, and help people complete the LIS application and select a Part D plan.

In most of the study states, other organizations—such as legal service agencies and ABCs—are active in LIS outreach and application assistance. ABC representatives highlight the ease and effectiveness of *Benefits CheckUp*, an online system maintained by the National Council on Aging (sponsor of ABCs) to screen people for eligibility for a variety of public benefits. The system makes it possible to enter personal data once; if the person appears to be LIS-eligible, the system populates the SSA LIS application form and sends it directly to SSA via the Internet.

MSP Screening and Referral. Study respondents in several states reported that counseling organizations, particularly SHIPs, are also helpful in screening LIS applicants for MSP eligibility. For example, an AAA in Alabama that receives SHIP funds screens people and helps them with both LIS and MSP applications; sometimes it even mails the MSP application and pays postage. The Massachusetts SHIP helps people apply for Medicaid and always submits the application with a letter authorizing the SHIP to receive copies of all correspondence from Medicaid, so the SHIP counselor can follow up on the outcome of the application process and

[35] The "donut hole"—also known as the "coverage gap"—refers to annual prescription drug costs above $2,250 and below $5,100 that are not typically covered by Part D plans. Persons with LIS do not face this coverage gap.

assist the applicant if necessary. The Kansas SHIP reported that it heavily markets MSP; employees make it a point to inform applicants that estate recovery rules do not apply to MSP in Kansas. A California legal service organization reported that it refers people to the state Medicaid agency because it screens applicants for both LIS and MSP. SHIP representatives reported having spoken with SSA officials about placing SHIP counselors in SSA field offices to screen Medicare beneficiaries for MSP; however, due to privacy concerns, the counselors had difficulty gaining access to the Internet from the field offices.

2. SPAP Requirements for LIS Applications

In states with SPAPs, enrollees may be required to apply for the LIS program as a condition of SPAP eligibility. Among the three study states with SPAPs, Massachusetts and Vermont required SPAP enrollees to apply for LIS as a condition of SPAP enrollment (see Table 3). If members qualify for LIS, the SPAP provides "wraparound" coverage to pay for some of the prescription drug costs not covered by a member's Part D plan. All three study states with SPAPs helped members apply for LIS through the SSA application process. As noted earlier, Vermont's SPAP (VPharm) helped enroll many of its members in the state's MSP after the state eliminated the asset test for MSP, thereby enrolling members in LIS as well. VPharm enrollees who were not eligible for MSP were required to apply for LIS through the SSA process; state officials said they try to identify and contact VPharm members who have not applied for LIS to help them do so.

Table 3. SPAP Eligibility Rules, LIS Application Policy, and Benefits

State Program Name	Income Limit	Asset Limit	Required to Apply to LIS	Wraparound Coverage
Massachusetts (Prescription Advantage)	500% FPL aged; 188% FPL disabled	None	Yes (for those with income below 188% FPL)	Premium assistance up to $363 annually; assistance with copayments; all out-of-pocket costs above $1,400
Missouri (Missouri Rx)	200% FPL	None	No	50% of all out-of-pocket costs outside Part D plan except premiums (includes deductible, copayments, and coverage gap)
Vermont (VPharm)	225% FPL	None	Yes	All out-of-pocket costs except a sliding-scale premium to VPharm of up to $35

The Massachusetts SPAP—Prescription Advantage—began operation in 2001. Under the program, enrollees with income under 188 percent of FPL are required to apply for LIS.

Beneficiaries receive the most financial assistance by enrolling in both programs, as LIS offers lower copayments and coverage through the donut hole, a benefit Prescription Advantage does not offer. In addition, the state can save money when SPAP members enroll in LIS and receive prescription drugs through Part D plans, freeing up state funds to extend the program to persons who do not receive Medicare who need help with prescription drug costs. The program conducts an aggressive campaign to help likely LIS-eligible members apply for the benefit. It sends letters that enclose an LIS application and contact information for SSA, the state's SHIP, and the SPAP. Prescription Advantage also conducts telephone outreach to SPAP members through a call center at the University of Massachusetts, offering to help beneficiaries complete LIS applications over the telephone and submit them online. If LIS-eligible SPAP enrollees do not enroll in LIS and a Part D plan, the SPAP increases their cost-sharing requirements, which it hopes will motivate them to apply for LIS. At the time to this study, the state had terminated 2,000 members for failure to apply.

In January 2006, the Missouri SPAP—Missouri Rx—began providing wrap-around coverage to persons with incomes up to 200 percent of FPL. All dual eligibles were automatically enrolled in the program in 2006, and enrollment was opened to all Part D enrollees with incomes up to 200 percent of FPL in 2007. Because Missouri Rx covers only half of the out-of-pocket costs for Part D enrollees and does not cover Part D premiums, the program alone provides a less generous benefit than LIS and Missouri Rx together. For this reason, the state encourages but does not require its enrollees to apply for LIS. Even though Missouri Rx does not have an asset test, its application asks for information on assets so the state can identify those who might qualify for LIS. The program uses computer-assisted technology to identify members who are LIS-eligible, informs them how to apply, tracks those who have applied, and sends reminders to those who have not yet applied. It also distributes LIS applications at outreach events. Missouri Rx estimates that 30 to 40 percent of its enrollees would not be eligible for LIS because of asset limits.

While SPAP officials in Massachusetts, Vermont, and Missouri reported that they worked with SSA to facilitate LIS applications by SPAP members, some SPAP officials said they would have appreciated more information-sharing. For example, they reported that they were not informed about the outcome of LIS applications submitted to SSA on behalf of their members. Two SPAP officials noted that they did not receive data from SSA on whether SPAP members had applied for LIS, which meant that the SPAPs had to conduct their own checks. However, one SPAP director reported that SSA did help determine whether its members had applied to LIS. It is not clear why their experience differs from the other two SPAPs.

IV. Factors That Promote or Hinder Access to LIS

Finding any door into LIS, particularly the most advantageous one, can be difficult for low-income Medicare beneficiaries who may have little experience applying for public benefits, little knowledge of LIS, or special needs related to physical or cognitive impairments, low literacy, or limited English proficiency. As part of this study, we asked all respondents to identify features of the LIS program and application processes that facilitate or present barriers to potentially eligible Medicare beneficiaries' efforts to apply to the program, or obtain help with the application process.

This section discusses respondents' views on the facilitators and barriers to applying for LIS as experienced by persons who may be eligible for the program. The discussion that follows summarizes responses and identifies factors specific to the application process as implemented by SSA, by state Medicaid agencies, and through coordination with community-based organizations.

A. Facilitators and Barriers to LIS Application

Study respondents noted six factors that help or hinder application for LIS (see Table 4): public information/education, application requirements, application form and modes for submitting it, availability of one-on-one assistance, federal-state-local coordination, and beneficiary concerns.

The barriers mirror some of those encountered in trying to locate and enroll eligible persons in MSP (Ebeler et al. 2006), including the stigma associated with applying for public benefits, fear of estate recovery (even though it is not a feature of the LIS program), and reluctance to disclose personal financial information. The barriers also include factors unique to the LIS program: the complexity of recruiting people in 2005 to sign up for a new program before the Part D program took effect in 2006, the difficulty in explaining the two-step application process (first to LIS and then enrollment in a Part D plan), and the use of two names for the same program ("LIS" and "extra help").

Some respondents also cited barriers created by Medicare Part D statutory requirements or SSA's LIS regulations, which make it difficult for some low-income beneficiaries to qualify for LIS. For example, SSA disregards $20 of an individual's monthly income, and a portion of earned income. SSA does not disregard the value of in-kind support from others, which can be hard for beneficiaries to keep track of, even though some interpret the MMA statute as giving SSA the ability to not count such support. Some respondents also believed the asset limits for LIS eligibility were too low and penalized people for saving.

The application process itself—the focus of this study—presents other barriers to enrollment, which could be corrected without changes in federal law or regulations. For example, public and private agencies at the state and local levels reported that people find it confusing to apply to SSA for a benefit administered by CMS and Part D plans. This suggests that Part D plans might play a greater role in helping potential LIS-eligibles apply for LIS. In addition, while many respondents reported that SSA's LIS application form is relatively short and straightforward, some said that to some beneficiaries it could seem long and intimidating. Respondents explained that many older people and people with disabilities are often overwhelmed by the prospect of filling out any form. But they also said that personalized assistance can help overcome

apprehension or hesitation about applying for benefits, indicating the importance of providing one-on-one help.

Table 4. Facilitators and Barriers to LIS Application

	Facilitators	Barriers
Public Information and Education	SSA and community partners conduct extensive outreach	SSA and other organizations supply too much information or difficult-to-understand written information Beneficiaries have difficulty understanding the need to apply to SSA for a Medicare benefit Beneficiaries do not understand or are confused by the two-step process to receive the LIS benefit (apply for LIS to SSA and then select/enroll in a Part D plan) Outreach occurred too early (before Part D plans became available) or overlapped too much with Part D open enrollment season "LIS" and "extra help" are both used to the refer to program, confusing beneficiaries The homebound and those not "plugged in" to community organizations lack awareness about the program
Application/Renewal Requirements	No documents need to be submitted to SSA to verify income or assets No new application is required for those already enrolled in MSP The renewal process requires no action if there is no change in income/asset and household situation	The income disregard ($20) is too little to permit those with incomes just above limits to qualify
Application Form, Modes, and Decision Notices	The SSA application is simple, uses large type, and is easy to fill out Beneficiaries can apply online or by mail (no need to apply in person) Beneficiaries can apply in SSA offices, which are located throughout the country and do not carry the stigma of welfare Paper applications are widely available LIS and MSP are combined into one application form	The SSA form is intimidating at eight pages (even though the length is due to large type and lots of white space) Beneficiaries are confused about the face versus cash value of life insurance SSA pre-notifications and denial letters are confusing or difficult to understand
Availability of One-on-One Assistance	One-on-one assistance is available from various sources and at community events Family members and caregivers can fill out the application on behalf of beneficiaries SSA offices have more bilingual speakers than do local Medicaid agencies	SSA field offices are crowded Transportation problems prevent some beneficiaries from obtaining one-on-one help
Federal-State-Local Agency Coordination	Federal agencies coordinate with community organizations to provide LIS application help and Part D plan counseling	SSA does not share information with organizations that are helping LIS applicants with the status of their applications CMS does not provide all states with leads data from SSA's LIS applicant files for MSP screening
Beneficiary Issues and Concerns		Beneficiaries are reluctant to apply for government benefits or disclose financial information to government agencies Beneficiaries are reluctant to share personal information at outreach and enrollment events Beneficiaries fear estate recovery (whether or not this fear is justified) Beneficiaries believe that they do not need the prescription drug benefit if they are not currently taking medication

For the most part, respondents agreed on the factors that facilitate or impede the LIS application process, but a few differences between respondent types are noteworthy. SSA and state Medicaid staff rarely cited as a barrier the stigma associated with applying for government benefits, although some recognized that some low-income people are reluctant to disclose financial information. SSA staff did not cite crowded offices or long lines in SSA field offices as impediments while respondents in community counseling and advocacy agencies did see such factors as important. Community counseling and advocacy staff said that SSA's pre-decisional and denial letters confuse applicants; they recommended that SSA reexamine the reading level of its form letters.

B. Facilitators and Barriers to SSA's LIS Application Process

According to study respondents, SSA's LIS application and eligibility determination process make it relatively easy for beneficiaries to apply for LIS. Respondents generally agreed that the application is relatively short and easy to fill out and noted that SSA's policy of not requiring applicants to submit documents to verify income or assets is particularly helpful. Even though beneficiaries find some of the information requests on the form to be confusing, respondents commended SSA for changing the form to clarify the questions that caused the most confusion or led to incorrect applications. For example, in 2006, SSA added space on the form for applicants to report Social Security benefits, because many LIS applicants were listing those benefits even though SSA already has access to this information. In addition, by making a variety of application modes available, including an online option, SSA has created opportunities for family members and staff in community organizations to assist applicants in whatever way is easiest for or most acceptable to the person. Because an in-person interview is not required, any interested person or group that understands the program can become an ancillary pathway to an LIS application door.

Owing to its experience in serving disabled persons who apply for SSI or SSDI, SSA is well-positioned to provide assistance to people with special needs. Moreover, staff in SSA field offices often reflect the ethnic, racial, and linguistic make-up of surrounding communities. But according to study respondents, crowded SSA field offices can make it difficult for potential LIS-eligibles to obtain personalized assistance from SSA staff.

C. Facilitators and Barriers to State Medicaid Agency LIS Application Processes

Almost every Medicaid agency in the study states has indicated its willingness to comply with MMA requirements but has also noted its belief that SSA is better equipped to enroll the non-deemed LIS population (those not automatically eligible for LIS through participation in MSP or Medicaid). With two exceptions, the state Medicaid agencies examined in this study have taken few measures to make it easier for potential LIS-eligibles to apply through their offices. Some of the study states' Medicaid agencies have issued memoranda to local eligibility offices regarding MMA requirements, directing them to accept and process LIS applications if requested, but they have not followed up with sufficient staff training or do not monitor compliance. In most study states, local Medicaid eligibility staff have been instructed to refer inquiries about LIS to SSA or local counseling organizations—this is similar to the practice reported by a majority of state Medicaid agencies (NASMD 2007).

In addition to believing that SSA could process LIS applications better than state Medicaid agencies, Medicaid directors and their staffs cite a number of other reasons for their limited efforts to find potential LIS-eligibles and help them apply for the program. Although the administrative expenses associated with processing LIS applications qualify for federal matching funds (50 percent of the cost), state Medicaid officials said their priority is to help dual eligibles become enrolled in Medicare prescription drug plans. They also are concerned that LIS applications could cause MSP rolls to grow and therefore increase state Medicaid costs. However, in a recent survey of state Medicaid directors, 19 of the 33 respondents (32 states and the District of Columbia) reported increases in MSP enrollment since the start of Medicare Part D, but only two attributed the increase to the LIS program (NASMD 2007).

Two study states have taken steps to make it easier for potential LIS-eligibles to apply or enroll in both LIS and MSP. The Kansas Medicaid agency has created a shortened MSP application form that can also be used to apply for LIS, eliminating the need for applicants to submit two forms. The state has received relatively few LIS applications on this form, but it has not advertised the form or encouraged intake staff to use it.

In Vermont, the state Medicaid agency has taken a different route. After learning from advocacy groups about the possibility of eliminating asset limits in its MSP, the state determined that it could generate savings for its SPAP if some SPAP members qualified for MSP. The state gained legislative approval for the policy change and filed a state plan amendment with CMS, then conducted an automated screening among SPAP members for income eligibility for the MSP. Many persons whose assets would have disqualified them for LIS became eligible for MSP and were, therefore, deemed eligible for LIS. Vermont demonstrates the potential of LIS to provide substantial help to low-income Medicare beneficiaries when the state Medicaid agency, SPAP, and advocacy organizations work together.

D. SSA, State Medicaid Agency, and Community Organization Coordination

According to study respondents, applying for LIS and undergoing eligibility screening for MSP is easier for Medicare beneficiaries when federal and state agencies and counseling or advocacy organizations can exchange data on potential eligibles. For example, community organization respondents in some of the study states reported that their personal relationships with local and regional SSA staff have provided them with the contacts they need to correct erroneous Social Security numbers entered on the LIS application or to resolve data exchange errors that produced unwarranted denial of LIS applications. In other states, community-based counselors lack such contacts and, owing to long wait times, cannot resolve these issues through the 800 number.

Privacy laws present significant barriers to such data exchanges, particularly when the data include income or asset information. For this reason, study respondents were skeptical that LIS leads data, supplied to state Medicaid agencies, will be useful in screening LIS applicants for potential MSP eligibility. For example, the leads data would have to specify the types and values of a person's assets for comparison with a state's MSP asset limits. However, among the study states with no asset limits (such as Arizona and Vermont), state officials noted that they would find the leads data useful for MSP outreach and screening purposes.

V. MAKING IT EASIER TO ENTER THE DOORS TO LIS

Between July 2005 and the end of 2006, SSA processed more than 5 million LIS applications and approved more than 2 million for LIS benefits. During the same period, state Medicaid agencies processed a few thousand LIS applications. An estimated 3 million potential LIS-eligibles remain unenrolled in LIS. Many of these people have low literacy, limited English skills, or physical or cognitive impairments. Another half million or more people who were automatically enrolled in LIS as dual eligibles (Medicare and Medicaid) may lose LIS benefits in 2008 if they become ineligible for Medicaid, as occurred in 2007.

Reaching these people and helping them apply for benefits through SSA or their state Medicaid agency is critical to fulfilling the promise of the Medicare Part D program. This report concludes with an assessment of the design and implementation features that have helped identify and enroll potential LIS-eligibles in the program. It also assesses barriers to enrollment and considers what could be done to overcome these barriers.

A. What Works Well

The views and experiences of federal, state, and community organization staff responsible for the LIS application process in the eight study states highlight several program features that have helped identify and enroll persons who are eligible for LIS and/or MSP.

- **SSA's Simplified LIS Application Process.** SSA has developed LIS application requirements, forms, and processes that are consistent across the country and has reduced some common barriers to applying for Medicare cost-sharing assistance by, for example, eliminating the need to submit documents to verify income and assets, reducing the stigma of applying for financial assistance, allowing applications to be submitted online and by telephone, and streamlining the redetermination process so that no action is necessary if an individual's income or assets remain unchanged.

- **State Initiatives to Help Low-Income Beneficiaries Obtain More Benefits.** Two of the study states—Kansas and Vermont—took advantage of the introduction of the LIS program to make it easier for low-income Medicare beneficiaries to apply and/or qualify for MSP without submitting separate applications. In addition, the Vermont, Massachusetts, and Missouri SPAPs have taken steps to make it easy for their program enrollees to apply for LIS, so that beneficiaries can receive more generous prescription drug coverage under Part D compared with enrolling in the SPAP alone.

- **Local Counseling Organizations as "Keys" to LIS Doors.** SHIPs, AAAs, ABCs, legal advocacy groups, and other community-based counseling organizations can help Medicare beneficiaries apply or qualify for LIS through the door most advantageous to the beneficiary. Local counseling agency staff in the study states have been instrumental in helping beneficiaries submit LIS applications to SSA, using their connections with local or regional SSA offices and other organizations to resolve problems that would otherwise prevent applicants from qualifying.

B. Remaining Obstacles

Several factors continue to make it difficult for all potentially eligible LIS Medicare beneficiaries to find the door to LIS that provides the easiest and most beneficial way to apply.

- **Little Involvement of State Medicaid Agencies in LIS Applications.** While all of the state Medicaid agencies and local social services offices interviewed for this study said they would accept and process LIS applications if an applicant specifically requested it, it is unusual in practice for local Medicaid eligibility workers to do much more than accept an LIS application and forward it to SSA for processing. Few state Medicaid agencies coordinate LIS outreach and education efforts with local SSA offices or train staff about LIS and LIS application processing.

- **Few States Use LIS as an Opportunity to Improve MSP Outreach and Enrollment.** Except in Vermont and Kansas, the introduction of the LIS program has not significantly changed how the study states conduct MSP screening and enrollment. Vermont and Kansas, however, have adopted strategies that offer potential models for other states interested in facilitating the LIS enrollment *through* MSP by making eligibility standards or application forms for the two programs more consistent and comprehensible to aged and disabled low-income Medicare beneficiaries.

- **Lack of LIS Leads Data for MSP Screening.** As of March 2007, states had yet to receive LIS applicant leads data.[36] It remains unclear whether all states would use the data for screening and outreach, but the data would be most relevant for states that have no asset limits and thus do not need asset information from the leads data to screen for MSP eligibility.

C. What Can Be Improved

Study respondents suggested several improvements to the LIS application process and the MSP screening and referral systems that would make it easier for LIS-eligible individuals to learn about and apply for LIS benefits.

- **SSA Communication with Medicare Beneficiaries Potentially LIS-Eligible.** Study respondents said that Medicare beneficiaries are overwhelmed by all the information sent to them about the Part D and LIS programs. To make it as easy as possible for Medicare beneficiaries to understand whether they might be eligible for LIS or MSP, study respondents recommended using simpler language in SSA letters. Respondents also recommended sending LIS or MSP outreach letters at a different time than the SSA letters informing beneficiaries about cost-of-living-adjustment (COLA) increases, Part B announcements, or open enrollment for Part D. Moreover, SSA might send letters during tax-filing season when more people are aware of their income. Study respondents also suggested that SSA letters appear in different colors for each program (e.g., Social Security,

[36] As this paper was going to print, states still had not received LIS leads data.

Medicare, Part D, LIS, and MSP) to help beneficiaries and their local counselors quickly identify the program to which the mailing pertains. In addition, SSA's public education campaigns need to distinguish clearly between LIS and Part D and emphasize the two-step application process.

- **State Medicaid Agency Involvement in LIS Applications and MSP Screening.** To fulfill the LIS program's potential to screen and enroll MSP-eligibles, state Medicaid agencies could be more engaged than they have been thus far in the LIS application process and MSP screening. Though many of the state Medicaid agencies in the study states voiced concern about the extra costs associated with increased MSP enrollment, the experience of the Vermont and Massachusetts SPAPs illustrates that other state programs might realize cost savings that would offset some of the projected extra costs.

  State Medicaid officials, together with SSA, could conduct more training of Medicaid eligibility workers, instructing them in how to proactively screen Medicare beneficiaries for LIS eligibility when these beneficiaries visit local social service offices for other reasons, rather than simply referring them to SSA or SHIPs for assistance with LIS applications. State Medicaid officials could consider developing a data exchange system so that SSA could provide LIS leads data directly to states rather than relying on CMS to provide the data. Alternatively, states could ask CMS to provide the data upon request to the states that are most interested in such data, potentially lessening the burden on CMS.

  State Medicaid agencies could also screen persons who are no longer eligible for Medicaid for LIS eligibility, and would therefore lose automatic LIS eligibility in the following year. State Medicaid agencies could share the lists provided by CMS containing the names of those losing automatic LIS eligibility the following year (possibly aggregated by ZIP code to address privacy concerns) with SHIPs and other groups for their use in conducting active outreach for MSP and LIS. This would augment CMS' and SSA's planned approach of sending a letter to each affected beneficiary containing SSA's LIS application.

  State Medicaid agencies could also use the information from the Medicaid or MSP applications of persons who do not qualify to screen for LIS eligibility. And, to make it easier to apply for MSP, states could take some lessons from SSA's design of the LIS program to improve the MSP application process. Changes might include making the MSP redetermination process passive (i.e., no response needed if income/assets remain unchanged); asking applicants to approve verification of income or assets through SSA or the IRS rather than requiring documentation; and reexamining the MSP application form to clarify and emphasize the point that applying for MSP does not subject the beneficiary to estate recovery. States that use short forms for MSP applications could also publicize those applications more aggressively and ensure that eligibility workers offer applicants the short-form option.

- **Data Sharing and Communication between SSA and State/Local Organizations.** Because state and local organizations other than Medicaid agencies play critical roles in LIS outreach and application assistance, it would help if SSA and CMS established regular communication and data-sharing agreements with those organizations for LIS application purposes. For example, it would be easier for SPAP applicants or enrollees to apply for LIS if SPAPs were able to enroll individuals directly in the program by submitting batch information to SSA from individuals' SPAP applications. SHIPs might also be able to identify and enroll more people in LIS if they (instead of or in addition to Medicaid agencies) could receive LIS leads. SPAPs, SHIPs, and counseling organizations could more easily track and resolve problems with LIS applications for the people they help if SSA shared information, such as pre-decisional letters and disapproval notices, for LIS applications filed with the assistance of these third parties. To address privacy concerns, SSA could add a box to the LIS application asking beneficiaries to authorize information-sharing with the person who helped them prepare the form, just as the income tax form allows for tax preparers.

- **Partnerships among Federal Agencies, State Medicaid Agencies, and Community-Based Organizations.** Because community-based organizations play a critical role in facilitating LIS applications and helping people find the best door through which to qualify for the most benefits, SSA and state Medicaid agencies could do more to support the efforts of these organizations. Study respondents said that the one-on-one assistance provided by community-based organizations is essential to motivate many older and disabled people to apply for LIS or MSP. Organizations with strong roots in their communities or strong connections to groups bound by race, ethnicity, language, religion, or nationality are particularly well-suited to providing LIS application assistance to hard-to-reach Medicare beneficiaries.

  To support the critical role played by community-based organizations, some of the federal funds currently allocated to SSA and CMS for LIS outreach and beneficiary assistance might be designated for partnerships with community-based organizations that are well-positioned to conduct targeted outreach and provide one-on-one counseling and support to potential LIS-eligibles. If privacy concerns could be adequately addressed, federal agencies could share lists of names and addresses of potentially eligible beneficiaries with community-based organizations and encourage the organizations to target outreach efforts and provide one-on-one assistance to applicants.

  In locations where SSA offices are overcrowded and have long lines, SSA might consider allowing staff from SHIPs or other community-based organizations to be stationed in SSA offices to screen LIS applicants for MSP. Staff in all community agencies would find it helpful to have updated contact lists of SSA and CMS liaisons so they could refer beneficiaries appropriately for assistance with different types of problems.

References

Centers for Medicare and Medicaid Services (CMS). (2002). Characteristics of dual eligible Medicare beneficiaries, 2002." Medicare Current Beneficiary Survey, 2002. Access to Care File, cited in Kaiser Commission on Medicaid and the Uninsured. Dual Eligibles Fact Sheet, Pub. No. 4091-05, February 2006.

Center for Medicare and Medicaid Services, Center for Medicaid and State Operations, Disabled and Elderly Health Programs Group, State Medicaid Director Letter, June 11, 2007. (not available on CMS website as of June 27, 2007).

Congressional Budget Office (CBO). (2004). *A detailed description of CBO's cost estimate for the Medicare prescription drug benefit*. Washington DC.

Ebeler, J., P. Van de Water, and C. Demchak (eds.). (2006). *Improving the Medicare savings programs*. Report of the Study Panel on Medicare/Medicaid Dual Eligibles. Washington, DC: National Academy of Social Insurance.

Fox, K. and L. Schofield. (2006). *The pharmacy coverage safety net: Variations in state responses to supplement Medicare Part D.* Portland, ME: University of Southern Maine, Muskie School of Public Service.

Hogan, B., 2007. "Vermont's Experience with VPharm and Medicare Savings Programs," Presentation at the State Solutions Summit, March 22 (Accessed June 2007 from www.statesolutions.rutgers.edu).

National Association of State Medicaid Directors (NASMD) (May 2007). Medicare Part D: An Update on Reimbursement to States and Coverage Policies for Dually Eligible Individuals. Washington, DC: NASMD.

National Conference of State Legislatures. (2006). State pharmaceutical assistance programs in 2006: Helping to make Medicare Part D easier and more affordable. Updated August 2006. Accessed August 2, 2006, from www.ncsl/programs/health/SPAPCoordination.htm.

Nemore, P., J. Bender, and W. Kwok. (2006). *Toward making Medicare work for low-income beneficiaries: A baseline comparison of the Part D low-income subsidy and Medicare savings programs eligibility and enrollment rules.* Menlo Park, CA, and Washington, DC: Center for Medicare Advocacy.

Partridge, L. (2006, December). Complexity, coordination and compromise: States and the Medicare drug benefit. A report from the Forum Session, August 4, 2006. National Health Policy Forum.

Rice, T. and K. Desmond. (2006, January). Who will be denied Medicare prescription drug subsidies because of the asset test? *American Journal of Managed Care 12*(1):46–54.

Rosenbach, M. and J. Lamphere. (January 1999). *Bridging the gaps between Medicare and Medicaid: The case of QMBs and SLMBs*. Report #9902. Washington, DC: AARP Public Policy Institute.

Smoucha, A., J. Ferber, C. Goldstein, J. Frost, and K. Warren. (2005). The 2005 Missouri Medicaid cuts: A guide for consumers, families and advocates. St. Louis, Missouri: Legal Services of Eastern Missouri, Public Benefits Project.

Social Security Administration (SSA). (2006, November). Status of Medicare LIS applications received, SSA completed decisions by state. Data as of 11/17/06. Accessed January 3, 2007, at www.statehealthfacts.org.

Summer, L. (2006). Accomplishments and lessons from the state solutions initiative to increase enrollment in the Medicare savings programs. *State Solutions*. Center for State Health Policy, Rutgers University. Accessed January 5, 2007, at www.statesolutions.rutgers.edu/Reports/LSummermay06.pdf.

Summer, L. and E. Ihara, (2005, December). *Simplifying enrollment in Medicaid and Medicare savings programs for the elderly and individuals with disabilities*. Issue Paper #2005-10.Washington DC: AARP Public Policy Institute.

U.S. Census Bureau. (2005). Current Population Survey, Annual Social and Economic Supplement.

U.S. Congress, House of Representatives Committee on Ways and Means. (2003). Report from the Committee on Ways and Means, to accompany H.R. 2473, Medicare Prescription Drug and Modernization Act of 2003, together with dissenting views, July 15, House Rept. 108-178, Part 2.

U.S. Department of Education. (2003). *The health literacy of America's adults*. Washington, DC: Institute of Education Services, National Center for Education Statistics.

U.S. Department of Health and Human Services (DHHS). (2005). Medicare prescription drug benefit final rule, *Federal Register*, v. 70, no. 18 (January 28).

U.S. Department of Health and Human Services (DHHS). (2006a, May 10). 37 million Medicare beneficiaries now receiving prescription drug coverage. CMS press release. Retrieved January 5, 2007, from www.hhs.gov/news/press/2006pres/20060510.html.

U.S. Department of Health and Human Services (DHHS). (2006b, June 14). Over 38 million people with Medicare now receiving prescription drug coverage. DHHS press release. Retrieved January 5, 2007, from www.hhs.gov/news/press/2006pres/20060614.html.

Williams, C., S. Goodell, J. Hoadley, E. O'Brien, and M. Kanter. (2005, July). *State pharmacy assistance programs at a crossroads: How will they respond to the Medicare drug benefit?* Changes in Health Care Financing and Organization Policy Brief. Washington, DC: Academy Health.

Appendix A

Table A-1. Characteristics of Study States

	Number of Elderly in 2004								Processing LIS applications ?	MSP rules more liberal than LIS?	SPAP
		<100% FPL (000s)		<125% FPL (000s)		<135% FPL (000s)		<150% FPL (000)			
	Total (000s)	Count (000s)	Row %	Count (000s)	Row %	Count (000s)	Row %	Count (000s)	Row %		
United States	35,213	3,457	9.8	5,804	16.5	6,902	19.6	8,414	23.9		
Alabama	501	71	14.2	112	22.4	131	26.1	155	30.9		X	
Arizona	773	74	9.6	115	14.9	143	18.5	164	21.3		X	
California	3,883	282	7.3	537	13.8	666	17.2	798	20.5	See note		
Florida	2,847	225	7.9	428	15.0	509	17.9	617	21.7	See note		Ended 1/06
Kansas	329	27	8.2	41	12.5	47	14.3	55	16.6	X		Ended 1/06
Massachusetts	723	63	8.7	112	15.5	130	18.0	160	22.1	See note		X
Missouri	715	59	8.3	121	16.9	156	21.8	202	28.2			X
Vermont	85	5	5.9	12	14.1	15	17.6	20	23.5		X	X

Note: State Medicaid officials in California, Florida, and Massachusetts issue written instructions to local social services offices to accept state LIS applications if requested.

Source: 2005 Current Population Survey, Annual Social and Economic Supplement, Table POV46.

Table A-2. Interview Topics for Key Informant Groups

<table>
<tr><td>Regional and Local SSA Staff</td><td>State Medicaid Eligibility Policy Staff</td><td>Local Social Services Agency Staff</td><td>State or Local SHIP and State SPAP Staff</td><td>Community-Based Organization Staff</td></tr>
<tr><td colspan="5">LIS OUTREACH AND APPLICATION ASSISTANCE</td></tr>
<tr><td colspan="5">Types of outreach and education to LIS-eligibles</td></tr>
<tr><td>Type of outreach and assistance provided to LIS applicants, including people with special needs</td><td>Reasons why or why not accepting LIS applications</td><td colspan="3">Type of outreach and assistance provided to LIS applicants, including people with special needs</td></tr>
<tr><td colspan="5">LIS ELIGIBILITY DETERMINATION, REDETERMINATION, AND APPEALS</td></tr>
<tr><td colspan="2">Role in LIS eligibility determination, appeals, and redetermination processes and procedures used</td><td colspan="3" rowspan="2">Familiarity with, and assessment of, SSA and state or local Medicaid implementation of LIS application, redetermination, and appeals processes</td></tr>
<tr><td></td><td>System for processing LIS applications in states that accept them</td></tr>
<tr><td colspan="5">Policies and practices and other factors that facilitate or create barriers to LIS applications
Other factors that contribute to variation in LIS applications/approvals in each state</td></tr>
<tr><td colspan="5">MSP ELIGIBILITY DETERMINATION/OTHER STATE PROGRAMS AND PRACTICES</td></tr>
<tr><td>Role/involvement in MSP outreach and referrals to state Medicaid agencies</td><td>Type of outreach, MSP “screen and enroll” policies, MSP eligibility changes, coordination with SSA and CMS on “leads data”</td><td>Type of outreach, MSP “screen and enroll” policies, MSP eligibility changes</td><td>MSP application assistance, requirements for SPAP enrollees to apply for LIS and help available</td><td>MSP application assistance, efforts to modify MSP rules or to encourage application to MSP and/or LIS</td></tr>
<tr><td colspan="5">Policies, practices and other factors that facilitate or create barriers to MSP applications
Ways in which LIS Part D outreach and enrollment practices facilitates or creates barriers to MSP enrollment</td></tr>
<tr><td colspan="5">IDEAS FOR IMPROVING LIS AND MSP APPLICATION PROCESSES</td></tr>
</table>

TABLE A-3. Medicaid Eligibility and Application Requirements in Study States

	Full Medicaid					Medicare Savings Programs				
	Aged/Disabled Limits		Medically Needy Limits							
	Income (% FPL)	Assets (Individual/couple	Income	Assets	Asset Limits	In-Kind Support Excluded	Self-Attestation of Income/ Assets	MSP-Only Application	Mail-In Option	Online Option
Alabama	74%	$2000/$3000	N/A	N/A	None [i, j]	Y	N/Y	Y	Y	
Arizona	74%	$2000/$3000	N/A	N/A	None [j]	Y	N/Y	Y	Y	
California	100% [a]	$2000/$3000	83%/97%	$2000/$3000	$4000/$6000			Y	Y	
Florida	90% [b]	$5000/$6000	25%/25%	$5000/$6000	$5000/$6000	Y	Y/Y	Y	Y	Y
Kansas	74%	$2000/$3000	66%/49%	$2000/$3000	$4000/$6000	Y		Y	Y	[l]
Massachusetts	100% [c]	$2000/$3000 [f]	100% [g]	$2000/$3000 [f]	$4000/$6000		Y/Y [k]	Y	Y	
Missouri	100% [d]	$1000/$2000	N/A	N/A	$4000/$6000	Y		Y	Y	
Vermont	82% [e]	$2000/$3000	102%/76% [h]	$2000/$3000	None [j]		Y/Y		Y	

Note: All study states used the federal income limits for MSP. More information on income disregards for full Medicaid and MSP is available from the sources below.

Source: Data on eligibility for full Medicaid are 2003 data from the National Association of State Medicaid Directors (www.nasmd.org/eligibility/statesummary.asp, accessed December 2006). Information on Medicare savings programs is from 2005 data from Nemore et al. (2006) and interviews with states in late 2006.

[a] California has SSP coverage up to 99% FPL and raised Medicaid income limits to 100% FPL under the OBRA '86 rules.
[b] Florida does not have SSP but raised income limits to 90% FPL under the OBRA 86 rules.
[c] Massachusetts offers Medicaid to SSP recipients and applies the OBRA '86 option to cover aged and disabled persons up to 100% FPL.
[d] Missouri, a 209(b) state, does not have a Medically Needy program but, as required, permits people to spend down. In 2005, the state tightened eligibility rules, lowering the spend-down limits to $678 for singles and $909 for couples and requiring those between 85% and 100% FPL to meet a monthly spend down amount that they previously did not have to meet (Smoucha et al., 2005).
[e] Vermont raises income limits to 82% FPL through SSP.
[f] Asset limit applies to those over age 65. Noninstitutionalized disabled persons do not have an asset limit.
[g] Massachusetts does not have an MNIL for persons with disabilities. For the elderly, the limit is 100% FPL, and federal SSI asset limits apply.
[h] Vermont uses a higher income standard of 111% FPL (individual) and 82% FPL (couple) for residents of Chittenden County only.
[i] The state disregards all assets for QMBs, but the asset test for SLMB is twice the SSI limit.
[j] States effectively remove the asset test by disregarding all assets.
[k] Applicants do not have to submit documentation with their applications, but the state can contact them to require them to provide documentation.
[l] Nemore et al. (2006) indicate that Kansas has an online MSP application; while state interview respondents said the application was available online, it cannot be filed online.

N/A = not applicable