THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

PERFORMANCE ON

THE GOVERNMENT PERFORMANCE AND RESULTS ACT (GPRA) MEASURE

TO "IMPROVE ACCESS TO CARE FOR ELDERLY AND DISABLED MEDICARE BENEFICIARIES WHO DO NOT HAVE PUBLIC OR PRIVATE SUPPLEMENTAL INSURANCE."

Prepared by:

The Centers for Medicare & Medicaid Services
The Center for Medicaid and State Operations
The Disabled and Elderly Health Programs Group
The Division of Eligibility, Enrollment and Outreach

April 15, 2002.

TABLE OF CONTENTS

NOTE: Full and more detailed information is available on the CMS web site, www.cms.hhs.gov/dualeligibles/derpthmp.asp

EXECUTIVE SUMMARY

This report provides an update on the Government Performance and Results Act (GPRA) measure to "*Improve Access to Care for Elderly and Disabled Medicare Beneficiaries Who Do Not Have Public or Private Supplemental Insurance."* The Centers for Medicare and Medicaid Services (CMS) has addressed this goal through activities aimed at the identification and enrollment of eligible beneficiaries in all programs designed to assist low-income individuals with Medicare premiums and cost-sharing amounts. In the 3-year history of this initiative, CMS has emphasized the Medicare Savings Program groups including Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualifying Individuals (QI-1, QI-2).

Performance data is available on the CMS website,
www.cms.hhs.gov/dualeligibles/derpthmp.asp

FY 2001 PERFORMANCE

National Target

The CMS FY 2001 GPRA target was to exceed the national enrollment rate increase collectively in the states that received a federal grant to pursue the identification and enrollment of dual eligibles. Largely through the efforts of the states and their partners, CMS met the national target in FY 2001.

The national target was an aggregate, numerical goal for the 6 states who received grants (CT, MD, MN, MT, TX, and WA). The collective growth rate was compared to the national enrollment growth rate and was measured using data from the CMS Buy-In System. The baseline was 652,302, which represented the number of enrolled dual eligibles in the grant states at the end of September 2000. The measure was the aggregate enrollment in the same States at the end of September 2001. **The cumulative enrollment rate for the 6 grant states of CT, MD, MN, MT, TX, and WA was an increased of 4.3%, which exceeded the national enrollment average increase of 3.6%.** The numerical enrollment in the 6 grant states was 680,451. If enrollment had increased at the national growth rate, the grant states would have only enrolled 675,785 beneficiaries, a difference of 4,666 beneficiaries. See Enclosure 1 for more information on the FY 2001 national target.

State Monitoring

In FY 2001, CMS also monitored the performance of each state. The general monitoring goal for each state was to increase the number of enrolled dual eligibles by 2%. The states were measured using the CMS Buy-In files or validated, state-reported data. The baseline, the number enrolled as of September 30, 2000, was compared to enrollment as of September 30, 2001.

If a state's enrollment increase was less than the 2% monitoring goal, CMS reviewed the state's performance against a number of other factors, also referred to as filters. These included: 1) the average 3-year enrollment rate for dual eligibles; 2) the rate of potential dual eligibles enrolled; 3) the utilization of the State's allotment for the Qualifying Individuals program; and 4) administrative simplification and outreach activities directly related to enrollment of the dual eligible population. A State was considered to have met their monitoring goal if they either met or exceeded a 2%

enrollment increase or met the criteria established for one of these filters. An explanation of the filters is contained in Enclosure 2.

In FY 2001, 48 states and the District of Columbia met or exceeded the performance criteria for the state-monitoring goal.

National and State performance information is contained in Enclosure 3. Enclosure 4 lists the top performing states in the areas of outreach, partnership, and enrollment simplification. More detailed information is available at the CMS website.

FY 2000 PERFORMANCE

National Target

Using historical data and statistical trending, a 4% enrollment target was established for FY 2000. This 4% target was double the historical growth rate of 2%. The total dual eligible enrollment target for the end of FY 2000 was 5,481,000, which was an overall increase of 314,000 enrolled beneficiaries over the 5,167,000 September 1998 baseline. The baseline was established using information from the CMS Medicare Buy-in file. The actual enrollment increase from October 1, 1998 through September 30, 2000 was 333,808. Therefore, **we exceeded the national 4% enrollment target by over 19,000 beneficiaries**, 106.3% of the national enrollment target.

State Monitoring

In addition to a National Target, each state was expected to meet or exceed a 4% enrollment increase or achieve goals for a number of other factors/filters. These filters, the same that were used in FY 2001, included the three-year enrollment growth rate, the enrolled percentage of potential beneficiaries, and the state's efforts to conduct activities directly related to the enrollment of the dual eligible population. These filters were utilized so that states that were already above the average enrollment rate were not penalized. The outreach filter also permitted those states that had invested in outreach and enrollment activities additional time to realize the benefits of their labor. Therefore, a state was considered to have met its specific monitoring goal if they either met or exceeded a 4% enrollment increase, or met the criteria established for these other filters.

A total of 47 States and the District of Columbia met their FY 2000 monitoring goal.

Enclosure 5 is a chart that contains state by state performance for FY 2000. Additional information on states is available at the CMS website.

STATE PROGRESS ON REDUCING BARRIERS TO ENROLLMENT

Much of the success of the last 3 years is the direct result of significant improvements and changes made by individual states. In FY 1999, CMS contracted with the American Public Human Services Association (APHSA) to conduct a baseline study on the states' activities to enroll dual eligibles. In FY 2001, we again contracted with APHSA to do a follow-up survey on the same factors to determine what progress had been made in the areas of outreach, partnership, and enrollment simplification. We are pleased to report that states have made significant strides in all 3 areas. According to survey results, the states showed particular progress in the following areas:

- There was a **major expansion in the variety of outreach materials** used. The traditional mailings and informational pamphlets still remain the most popular, but new destinations such as providers, family members, and community organizations were targeted. Other creative materials used were everyday useful products such as door magnets, jar grippers, place mats, and pillboxes. Over 90% of states focused significant attention on this aspect.

- There was a **renewed focus on and expansion of consumer and staff education and training**. This resulted in more live presentations, telephone hotlines, onsite visits, targeting of special populations, and staff training sessions. Over 70% of states spent considerable resources in these areas.

- **Partnerships were expanded**, and in some cases state-wide coalitions were formed, with other federal, state, county, and local government agencies, and local community groups, faith-based organizations, and health care providers. These enhanced efforts reached more potential beneficiaries.

- **The most dramatic improvement was in the application, enrollment and eligibility process.** A simplified application is now implemented or a near reality in 80% of the states compared to only 24% at the start of the GPRA measure. Additionally, over 95% of all states now use a streamlined redetermination process. These major reductions in barriers have increased the number of individuals on the rolls and reduced the number who may fall out during recertification. To help streamline the process even more, many states have eliminated the office in-person requirement.

Enclosure 6 is the text of the report entitled, "Promoting and Supporting the Medicare Savings Programs." The full report is available on the CMS website.

DEVELOPMENT OF A MODEL APPLICATION

The Benefits Improvement and Protection Act (BIPA) of 2000 requires the Secretary of Health and Human Services (HHS) to develop **a simplified national application form** for states, at their option, to use for certain low-income Medicare beneficiaries who apply under the Medicaid program for assistance with Medicare cost-sharing.

The development of this model application was a joint federal-state effort. Starting with an existing model application for the Medicare Savings Programs, CMS worked with the Medicaid Eligibility Technical Advisory Group to develop a revised model application. Before finalizing this application, CMS sought and incorporated comments from a large partnership network, which included many beneficiary advocacy organizations, providers, and other Federal agencies.

The final product represents a significant opportunity to simplify the application process for those states that have not already done so. However, to be truly effective, a simplified application is only one step. A state must also implement other simplification measures such as: making the application available at locations convenient to beneficiaries; training local partners on how to assist with the application; allowing for mail/fax/internet applications; and removing in-person requirements and other extravagant and burdensome verification measures.

Enclosure 7 contains The Model Application. It is also available on the CMS website.

ATTACHMENT 1

GPRA PERFORMANCE GOAL #1
2001 CMS NATIONAL TARGET REPORT
Sep-01
(From Third Party Premium Billing File, November 2001)

STATE (Grantee States in Bold)	Sept '00 Baseline	(Nov Buy-In) Sept '01 Enrollment	% Enrollment Increase
Alabama	137,828	142,696	3.5%
Alaska	8,713	9,163	5.2%
Arizona	58,646	67,040	14.3%
Arkansas	79,595	81,164	2.0%
California	827,399	857,140	3.6%
Colorado	56,217	57,575	2.4%
Connecticut	**53,956**	**58,786**	**9.0%**
Delaware	11,316	12,485	10.3%
District of Columbia	14,301	14,723	3.0%
Florida	348,928	363,111	4.1%
Georgia	177,934	184,405	3.6%
Hawaii	20,828	21,272	2.1%
Idaho	17,549	19,025	8.4%
Illinois	156,051	163,863	5.0%
Indiana	89,471	95,033	6.2%
Iowa	52,240	53,432	2.3%
Kansas	41,571	42,440	2.1%
Kentucky	117,690	120,825	2.7%
Louisiana	116,459	118,429	1.7%
Maine	37,332	38,650	3.5%
Maryland	**65,078**	**68,906**	**5.9%**
Massachusetts	155,923	160,364	2.8%
Michigan	146,166	149,672	2.4%
Minnesota	**64,672**	**68,368**	**5.7%**
Mississippi	109,646	120,814	10.2%
Missouri	89,180	92,068	3.2%
Montana	**12,853**	**13,142**	**2.2%**
Nebraska	20,697	21,391	3.4%
Nevada	19,513	20,992	7.6%
New Hampshire	7,542	8,965	18.9%
New Jersey	148,075	151,213	2.1%
New Mexico	37,838	40,065	5.9%
New York	389,422	400,096	2.7%
North Carolina	226,176	231,390	2.3%
North Dakota	5,954	6,335	6.4%
Ohio	173,420	178,995	3.2%
Oklahoma	67,154	68,208	1.6%
Oregon	60,223	64,180	6.6%
Pennsylvania	209,810	216,175	3.0%
Rhode Island	20,445	22,173	8.5%
South Carolina	113,512	117,854	3.8%
South Dakota	13,222	13,370	1.1%
Tennessee	183,831	186,152	1.3%
Texas	**364,627**	**373,595**	**2.5%**
Utah	16,384	16,907	3.2%
Vermont	13,835	14,393	4.0%
Virginia	113,798	114,737	0.8%
Washington	**91,116**	**97,654**	**7.2%**
West Virginia	46,668	47,641	2.1%
Wisconsin	74,018	74,269	0.3%
Wyoming	6,580	6,842	4.0%
NATIONAL	5,491,402	5,688,183	3.6%
GRANTEE STATES	652,302	680,451	4.3%

ATTACHMENT 2

Methodology for Measuring Performance of State Monitoring Goals and State Enrollment Targets

In FY 2001, using validated state reported data or CMS Buy-In data, CMS will compare the number of enrolled dual eligibles in the state to the state enrollment goal or the state enrollment target. In FY 2001, the numerical monitoring goal is 102% of the Sept. 2000 enrolled and the numerical target is 104% of the number enrolled on Sept. 30, 2000.

If the state increase in enrollment for the year is greater than the state monitoring goal or target, the state will not be considered for a state-specific enrollment target in the next year. If a state's enrollment increase is less then the state's goal or target, CMS will review the state's performance against a number of other factors (filters) to determine if a state-specific enrollment target should be set for the state.

These filters include:

1. **Three Year Enrollment Growth Rate** CMS will examine the state's three year state enrollment growth rate for duals. If a state's three year enrollment growth rate for duals is at or greater than the national rate, the state will not receive a state specific target.

2. **The Dual Eligible Penetration Rate** The percentage of potential beneficiaries who are participating in a dual eligible program. This percentage will be derived by comparing the state reported enrollment numbers against the total number of potential eligibles, as calculated using the methodology developed by the Actuarial Research Corporation (ARC). Once a state-specific percentage is determined, the state rate will be compared to the national estimate of potential duals that are enrolled. If the state rate is at or above the national rate, the state will not receive a state-specific target

3. **Allotment for the Qualifying Individual Program** If a state has utilized 90 percent of the allotment that is available for the Qualifying Individual Program, the state will not receive a state-specific target. As rationale, it is assumed that the state has undertaken significant outreach and enrollment efforts to enroll this population, and would have identified individuals eligible for the other programs in the course of doing so.

4. **Administrative Simplification and Outreach Activities** If a state does not meet one of the first three screens, CMS will examine the state's activities directly related to enrollment of the dual eligible population. To be considered, these activities must be reported to the CMS regional offices in the quarter following in which they occurred. A state that has made a good faith effort to conduct a number of activities directly related to the enrollment of the dual eligible population would not receive a state-specific target.

ATTACHMENT 3

GPRA PERFORMANCE GOAL #1

FY 2001 NATIONAL AND STATE LEVEL PERFORMANCE INFORMATION

STATE (Grantee States in Bold)	Sept '00 Baseline [a]	Sept '01 Goal (2% Increase)	Actual Enrollment Sept '01 [a]	Enrollment Increase 09 '00 - 09 '01	% Enrollment Increase 09 '00 - 09 '01	% Increase Above National Avg	Notes
STATES ACHIEVING NUMERICAL MONITORING GOAL							
Alabama	137,828	140,585	142,696	4,868	3.5%	-0.1%	
Alaska	8,713	8,887	9,163	450	5.2%	1.6%	
Arizona	58,646	59,819	67,040	8,394	14.3%	10.7%	
Arkansas	79,595	81,187	81,164	1,569	2.0%	-1.6%	Enrollment increase of 1.97% is rounded to 2.0%. Since this is well within the margin of any error, the State is listed as having achieved monitoring goal.
California	827,399	843,947	857,140	29,741	3.6%	0.0%	
Colorado	56,217	57,341	57,575	1,358	2.4%	-1.2%	
Connecticut	**53,956**	**55,035**	**58,786**	**4,830**	**9.0%**	**5.4%**	
Delaware	11,316	11,542	12,485	1,169	10.3%	6.7%	
District of Columbia	14,301	14,587	14,723	422	3.0%	-0.6%	
Florida	348,928	355,907	363,111	14,183	4.1%	0.5%	
Georgia	177,934	181,493	184,405	6,471	3.6%	0.0%	
Hawaii	20,828	21,245	21,272	444	2.1%	-1.5%	
Idaho	17,549	17,900	19,025	1,476	8.4%	4.8%	
Illinois	156,051	159,172	163,863	7,812	5.0%	1.4%	
Indiana	89,471	91,260	95,033	5,562	6.2%	2.6%	
Iowa	52,240	53,285	53,432	1,192	2.3%	-1.3%	
Kansas	41,571	42,402	42,440	869	2.1%	-1.5%	
Kentucky	117,690	120,044	120,825	3,135	2.7%	-0.9%	
Maine	37,332	38,079	38,650	1,318	3.5%	-0.1%	
Maryland	**65,078**	**66,380**	**68,906**	**3,828**	**5.9%**	**2.3%**	
Massachusetts	155,923	159,041	160,364	4,441	2.8%	-0.8%	
Michigan	146,166	149,089	149,672	3,506	2.4%	-1.2%	
Minnesota	**64,672**	**65,965**	**68,368**	**3,696**	**5.7%**	**2.1%**	
Mississippi	109,646	111,839	120,814	11,168	10.2%	6.6%	
Missouri	89,180	90,964	92,068	2,888	3.2%	-0.4%	
Montana	**12,853**	**13,110**	**13,142**	**289**	**2.2%**	**-1.4%**	
Nebraska	20,697	21,111	21,391	694	3.4%	-0.2%	
Nevada	19,513	19,903	20,992	1,479	7.6%	4.0%	
New Hampshire	7,542	7,693	8,965	1,423	18.9%	15.3%	
New Jersey	148,075	151,037	151,213	3,138	2.1%	-1.5%	
New Mexico	37,838	38,595	40,065	2,227	5.9%	2.3%	
New York	389,422	397,210	400,096	10,674	2.7%	-0.9%	
North Carolina	226,176	230,700	231,390	5,214	2.3%	-1.3%	
North Dakota	5,954	6,073	6,335	381	6.4%	2.8%	
Ohio	173,420	176,888	178,995	5,575	3.2%	-0.4%	
Oregon	60,223	61,427	64,180	3,957	6.6%	3.0%	
Pennsylvania	209,810	214,006	216,175	6,365	3.0%	-0.6%	
Rhode Island	20,445	20,854	22,173	1,728	8.5%	4.9%	
South Carolina	113,512	115,782	117,854	4,342	3.8%	0.2%	
South Dakota	13,222	13,486	13,370	148	1.1%	-2.5%	Exceeded State Monitoring Goal by 64 using validated, State Self-Reported Data.
Texas	**364,627**	**371,920**	**373,595**	**8,968**	**2.5%**	**-1.1%**	
Utah	16,384	16,712	16,907	523	3.2%	-0.4%	
Vermont	13,835	14,112	14,393	558	4.0%	0.4%	
Washington	**91,116**	**92,938**	**97,654**	**6,538**	**7.2%**	**3.6%**	
West Virginia	46,668	47,601	47,641	973	2.1%	-1.5%	
Wyoming	6,580	6,712	6,842	262	4.0%	0.4%	

STATE	Sept '00 Baseline [a]	Sept '01 Goal (2% Increase)	Actual Enrollment Sept '01 [a]	Enrollment Increase 09 '00 - 09 '01	% Enrollment Increase 09 '00 - 09 '01	% Increase Above National Avg	3-Year Enrollment % Increase 09 '98 - 09 '01 [b]	% Potentials Sept '01 [c]	Outreach [d]
STATES ACHIEVING MONITORING GOAL THROUGH ADDITIONAL GOAL METHODOLOGY									
Louisiana	116,459	118,788	118,429	1,970	1.7%	-1.9%	NO	NO	**YES**
Tennessee	183,831	187,508	186,152	2,321	1.3%	-2.3%	NO	**YES**	NO
Virginia [e]	113,798	118,350	114,737	939	0.8%	-2.8%	NO	NO	**YES**
STATES NOT ACHIEVING MONITORING GOAL									
Oklahoma [e]	67,154	69,840	68,208	1,054	1.6%	-2.0%	NO	NO	NO
Wisconsin [e]	74,018	76,979	74,269	251	0.3%	-3.3%	NO	NO	NO
NATIONAL	5,491,402	5,606,329	5,688,183	196,781	3.6%		10.1%	59.5%	

Column Notes:

[a] Source of Data is the CMS Third Party Premium Billing File (Buy-In Report).

[b] YES: State's 3-Year Enrollment Increase (09 '98 - 09 '01) exceeds the national rate; NO: State's 3-Year Enrollment rate is less than the national rate.

[c] YES: State's percentage of enrolled potential dual eligibles exceeds the national estimated rate of enrolled potential duals;
NO: State's percentage of enrolled potential dual eligibles is less than the national estimated rate of enrolled potential duals.
Source of data is the Actuarial Reseach Corporation (ARC).

[d] YES: State's documented Outreach/Administrative Simplification efforts were extensive; NO: State's documented Outreach/Administrative Simplification efforts were not extensive.

[e] Monitoring Goal will be a 4% enrollment increase.

ATTACHMENT 4

2001 GPRA PERFORMANCE GOAL #1
STATE LEVEL OUTREACH & ADMINISTRATIVE SIMPLIFICATION
HIGHEST PERFORMING STATES
(In Alphabetical Order)

OVERALL	Outreach	Partnership	Application	Miscellaneous
Arizona	Arizona	Arizona	Alabama	Alabama
Connecticut	Connecticut	Colorado	Arkansas	Alaska
Delaware	Indiana	Indiana	Connecticut	Arkansas
Indiana	Louisiana	Louisiana	Delaware	Delaware
Louisiana	Maine	Maine	Indiana	Georgia
Maine	Maryland	Maryland	Kansas	Iowa
Michigan	Michigan	Michigan	Minnesota	Kentucky
Minnesota	Minnesota	Montana	Montana	Louisiana
Montana	Missouri	New Hampshire	New Jersey	Maryland
New Jersey	Montana	North Dakota	South Dakota	Michigan
South Dakota	New Hampshire	South Dakota	Texas	Mississippi
Texas	South Dakota	Washington	Utah	Montana
Utah	Utah	Wyoming	Virginia	New Jersey
Washington	Washington		West Virginia	South Carolina
Wyoming	West Virginia			South Dakota
	Wyoming			Wyoming

ATTACHMENT 5

GPRA PERFORMANCE GOAL #1

FY 2000 NATIONAL AND STATE LEVEL PERFORMANCE INFORMATION

STATE	Sept '98 Baseline [a]	Sept '00 Goal [a]	Actual Enrollment Sept '00 [a]	Variance From Goal [b]	Notes
STATES ACHIEVING NUMERICAL MONITORING GOAL					
Alabama	124,142	131,690	137,828	6,138	
Alaska	7,493	7,949	8,713	764	
Arizona	51,827	54,978	58,646	3,668	
Colorado	52,870	56,084	56,217	133	
Delaware	9,332	9,899	11,316	1,417	
District of Columbia	14,451	15,330	14,301	*-1,029*	Exceeded State Monitoring Goal by 675 using validated, State Self-Reported Data.
Florida	318,607	337,978	348,928	10,950	
Hawaii	19,374	20,552	20,828	276	
Idaho	15,228	16,154	17,549	1,395	
Illinois	148,334	157,353	156,051	*-1,302*	Exceeded State Monitoring Goal by 1,706 using validated, State Self-Reported Data.
Indiana	79,530	84,365	89,471	5,106	
Kansas	39,664	42,076	41,571	*-505*	Exceeded State Monitoring Goal by 59 using validated, State Self-Reported Data.
Kentucky	107,534	114,072	117,690	3,618	
Maine	33,795	35,850	37,332	1,482	
Massachusetts	141,420	150,018	155,923	5,905	
Michigan	137,754	146,129	146,166	37	
Minnesota	58,375	61,924	64,672	2,748	
Missouri	82,891	87,931	89,180	1,249	
Montana	11,976	12,704	12,853	149	
Nebraska	18,181	19,286	20,697	1,411	
Nevada	17,510	18,575	19,513	938	
New Hampshire	6,410	6,800	7,542	742	
New Mexico	34,735	36,847	37,838	991	
New York	366,815	389,117	389,422	305	
North Carolina	212,223	225,126	226,176	1,050	
North Dakota	5,571	5,910	5,954	44	
Oregon	53,324	56,566	60,223	3,657	
Pennsylvania	189,731	201,267	209,810	8,543	
Rhode Island	17,790	18,872	20,445	1,573	
South Carolina	106,412	112,882	113,512	630	
Tennessee	172,196	182,666	183,831	1,165	
Texas	342,553	363,380	364,627	1,247	
Utah	14,904	15,810	16,384	574	
Washington	90,145	95,626	99,063	3,437	
West Virginia	43,228	45,856	46,668	812	
Wyoming	6,017	6,383	6,580	197	

STATE	Sept '98 Baseline [a]	Sept '00 Goal [a]	Actual Enrollment Sept '00 [a]	Variance From Goal [b]	3-Year Enrollment % Increase [c]	% Potentials [d]	Outreach [e]
STATES ACHIEVING MONITORING GOAL THROUGH ADDITIONAL GOAL METHODOLOGY							
Arkansas	78,826	83,619	79,595	*-4,024*	NO	**YES**	NO
California	780,960	828,442	827,399	*-1,043*	NO	**YES**	NO
Connecticut	51,594	54,731	53,956	*-775*	NO	**YES**	**YES**
Georgia	170,463	180,827	177,934	*-2,893*	NO	**YES**	**YES**
Iowa	50,466	53,534	52,240	*-1,294*	NO	**YES**	NO
Louisiana	115,652	122,684	116,459	*-6,225*	NO	**YES**	**YES**
Maryland	61,587	65,331	65,078	*-253*	NO	NO	**YES**
Mississippi	106,339	112,804	109,646	*-3,158*	NO	**YES**	**YES**
New Jersey	141,844	150,468	148,075	*-2,393*	**YES**	NO	NO
Ohio	181,060	192,068	173,420	*-18,648*	NO	NO	**YES**
South Dakota	13,011	13,802	13,222	*-580*	NO	NO	**YES**
Vermont	13,316	14,126	13,835	*-291*	NO	**YES**	**YES**
STATES NOT ACHIEVING MONITORING GOAL							
Oklahoma	63,809	67,689	67,154	*-535*	NO	NO	NO
Virginia	109,752	116,425	113,798	*-2,627*	NO	NO	NO
Wisconsin	74,520	79,051	74,018	*-5,033*	NO	NO	NO
NATIONAL	5,165,541	5,479,606	5,499,349	19,743	9.0%	57.0%	

Column Notes:

[a] Source of Data is the CMS Third Party Premium Billing File (Buy-In Report).

[b] Amount that the Actual Enrollment in Sept '00 exceeded the State Monitoring Goal or (*italics)* the amount short of the State Monitoring Goal.
States that exceeded their numerical Monitoring Goals are not subject to the additional steps in the goal methodology.

[c] YES: State's 3-Year Enrollment Increase (9 '97 - 9 '00) exceeds the national rate; NO: State's 3-Year Enrollment rate is less than the national rate.

[d] YES: State's percentage of enrolled potential dual eligibles exceeds the national estimated rate of enrolled potential duals;
No: State's percentage of enrolled potential dual eligibles is less than the national estimated rate of enrolled potential duals.
Source of data is the Actuarial Reseach Corporation (ARC).

[e] YES: State's documented Outreach/Administrative Simplification efforts were extensive; NO: State's documented Outreach/Administrative Simplification efforts were not extensive.

ENCLOSURE 6

PROMOTING AND SUPPORTING THE MEDICARE SAVINGS PROGRAMS
December 26, 2001

Executive Summary

The Social Security Act recognizes that, although Medicare provides health coverage to almost all the nation's elderly, and a significant percent of individuals with a disability, there are substantial numbers of low-income Medicare beneficiaries for whom Medicare premium and cost-sharing requirements often prove too costly. Since 1988, Congress has required state Medicaid programs to supplement Medicare by paying certain out-of-pocket expenses for low-income Medicare beneficiaries. More recent reforms extend these protections, termed the dual eligible benefits, but also commonly called, and henceforth referred to in this report as, the Medicare Savings Programs, to all Medicare-eligible individuals with limited resources and incomes ranging up to 200% of the federal poverty level.

Because state Medicaid programs are responsible for the management of these programs, no two states' administration of the Medicare Savings Programs are alike. In late 1998, we surveyed states on their outreach and enrollment choices for the Medicare Savings Programs' populations. Now, two years later, following a notable federal-state-local partnership geared entirely toward increasing enrollment in these often under-utilized programs, we report back on the changes and progress being made in states as they make significant efforts to better educate their target population and eliminate the perception of barriers within the enrollment process.

The following findings materialized:

- Most states continue to use a combination of outreach materials to educate consumers about dual eligible benefits, though the variety of outreach materials used has expanded. Printed materials, especially mailings and pamphlets, prove to be the most popular methods of outreach.
- States have instituted an increased focus on educating both consumers and state staff on the Medicare Savings Programs.
- Almost all state Medicaid agencies use partnerships with other agencies and organizations to enhance outreach efforts and reach more consumers.
- Many states have formed statewide task forces to help promote issues and solutions involving the Medicare Savings Programs.
- States have been especially conscientious about eliminating potential barriers to enrollment in the Medicare Savings Programs. Almost four times as many states currently use shortened application forms for the Medicare Savings Programs' beneficiaries. States have also worked to avoid requiring applicants to use the county social service office during the eligibility determination and enrollment process.

Introduction

Federal law requires that state Medicaid programs pay for Medicare costs for certain low-income people who are elderly or have disabilities. These people fall into a variety of Medicaid eligibility categories including, but not limited to, the Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), Qualified Disabled and Working Individuals (QDWIs), and Qualifying Individuals (QIs). Collectively, they are known as beneficiaries of the dual eligible programs, also known as the Medicare Savings Programs.

Medicare Savings Programs' beneficiaries do not all qualify for full Medicaid benefits based on their income, but they all receive assistance with a portion of their out-of-pocket expenses for hospital, physician, and other services covered by Medicare and/or a portion of the Medicare premium. Unless specified otherwise, this report will refer generally to "Medicare Savings Programs," meaning the range of protections—from full Medicaid benefits to Medicaid payment of Medicare premiums, deductibles, and coinsurance to Medicaid assistance with a small portion of Medicare premiums.

A concerted federal-state-local effort has recently been made to further promote the Medicare Savings Programs and encourage increased participation. In the early years of these benefits, many elderly and individuals with a disability did not take advantage of the obvious financial benefits of these programs.

The suggested explanations were numerous, including:

- Lack of knowledge about the programs.
- Lack of understanding about the benefits of the programs.
- Stigma associated with a benefit administered by Medicaid ("welfare").
- Lengthy, complex application forms.

According to the results of a survey we conducted in late 1998, the success of outreach and enrollment techniques designed to increase interest and enrollment in the Medicare Savings Programs varied by state. This current study[1] tracks the significant improvement made by individual states in these areas over the past two years based on state activities during federal fiscal year (FFY) 2000. We concentrated especially on state efforts to eliminate the theorized barriers to enrollment. For more detailed state-by-state information on most subjects covered in the body of this report, please review the appendix.

Part I: Outreach Materials

All fifty states and the District of Columbia volunteered significant data on their experience with information dissemination designed to increase understanding of and participation in the Medicare Savings Programs. We surveyed states on their use of printed materials, broadcast methods, and education efforts to outreach to this population.

[1] A copy of the current survey is available through CMS by calling John Kapustka at (410)786-4693.

Printed Materials

Almost all states—forty-six—use some sort of printed material to outreach, either directly or indirectly, to potential Medicare Savings Programs' beneficiaries. The most popular method was by letter, though it varied as to whom states directed these letters. Twenty-nine states, up from 21 in our previous survey, chose to mail letters directly to potential beneficiaries, hoping the financial benefits of the programs would catch their eye. In many cases, these type letters were developed in concert with the Center for Medicare & Medicaid Services (CMS).

The two most common data sources available to states for direct mailings to potential beneficiaries are (1) the State Data Exchange (SDX) on SSI beneficiaries, available through the Social Security Administration (SSA) and (2) the leads data from CMS which identifies Medicare beneficiaries who may be eligible for Medicare Savings Programs. Both sets of data are available on a monthly basis. According to recent survey data, of the eighteen states that make their own Medicaid eligibility determination for individuals eligible for SSI (the non-1634 states), eleven use the SDX file from SSA in order to outreach to potential beneficiaries. Twenty-three states received the leads data from CMS during the survey period. Even more indicated plans to do so in the near future.

States do not limit their direct outreach letters to supposed potential beneficiaries, but also target mailings to community health centers, providers, grass root organizations, or family members of potential beneficiaries. This technique makes certain that those who come into frequent contact with potential Medicare Savings Programs' beneficiaries are aware of the programs and their benefits and can help explain and encourage participation. Along these same lines, five states arranged to put flyers advertising the Medicare Savings Programs into other mailings, such as utility bills, that go to low-income elderly and individuals with a disability. These methods are less direct, but may catch potential beneficiaries who are not otherwise known to the state through existing data clues.

Pamphlets, used by thirty-four states, were also a popular print method of spreading knowledge of the programs. Pamphlets were used in a variety of ways, including on their own at government offices and other sites potential Medicare Savings Programs' beneficiaries were likely to visit, as an insert in informational mailings, or in conjunction with a shortened application. Posters and newspaper notices were utilized to a lesser extent, possibly because their efficacy is more difficult to determine and track.

Over seventeen states volunteered other creative print materials they used during their outreach campaigns, including door magnets, jar grippers, placemats, calendars, and even pillboxes. Not all of the ideas were product-oriented, however. States printed benefits guides that were available for order by agency staff for use in field office pamphlet racks or application packets. State staff wrote articles and advertisements to be included in newsletters that reach such diverse groups as Area Agencies on Aging (AAAs) or

Medicaid providers or tried to reach people by billboard ads. Some states consider their Medicare Savings Programs application an outreach tool itself.

Broadcast

While relatively fewer states chose to promote Medicare Savings Programs through broadcast methods on radio or television, more than half of those that did (eleven) generally used several such options. Fourteen states had staff participate on talk shows (either radio or television), making that the most popular broadcast method for explaining the Medicare Savings Programs. Radio public service announcements were used by thirteen states. Relatively few states use television public service announcements, paid commercials, or appearances on local cable access channels to promote the programs, likely due to the higher costs of these options.

Education

A notable forty states use live presentations by state personnel to educate potential beneficiaries and encourage Medicare Savings Programs participation, though type and amount of these presentations vary dramatically depending on the state. States may present at health fairs, small groups, one-on-one, or even door-to-door. Generally, states seemed to concentrate on health fair and small group presentations, probably because of the increased likelihood of a chance of enrollment success with more listeners.

A growing number of states, thirteen, have a dedicated phone hotline for information and inquiries concerning the Medicare Savings Programs and an additional six states have such assistance available on a more general state health insurance hotline. While our 1998 survey indicated that states felt internet pages explaining the Medicare Savings Programs might be wasted on a population that might not be computer-savvy, over twenty-one states have developed or are in the process of constructing such web pages, possibly due to the increasing computer literacy of the aged and disabled population.

States have also tried to go to the potential beneficiaries, rather than wait for them to approach the state. One state uses an outreach van, parked in different locations to disseminate information. Another makes regular visits to Native American reservations and other insular communities where potential Medicare Savings Programs' beneficiaries might live. At least two states have invested in a mini grant program where local health advocates tailor a multi-media outreach package to the needs of their county.

Over thirty-five states target various segments of their own staff—everyone from the obvious Medicaid eligibility workers to AIDS social workers to legal staff—with education specific to these programs so as to better serve potential beneficiaries during the outreach and enrollment processes. This training may be designed for new workers and/or as a refresher course for current staff; it may be presented live or in printed form as a "desk aid." States also spend valuable resources to train non-staff including Medicaid providers, SSA workers, and community health advocates.

Twenty-three states make a special effort to target specific minority or special population beneficiaries. Most of these efforts are aimed at Hispanic, African American, or Native

American populations. Minnesota reports making special efforts to attract five minority populations—Russian, Hispanic, Hmong, Vietnamese, and Native American. A few states reported focusing specifically on urban and/or rural locations which each pose different issues for potential Medicare Savings Programs' beneficiaries.

Part II: Dual Eligible Specific Partnership Efforts of State Medicaid Agencies

The survey asked states with whom they partner when trying to attract attention to the Medicare Savings Programs. Almost every state, an increase from the 37 states in our 1998 survey, utilizes partnerships with other organizations—whether they are state agencies, other government entities, providers, or advocacy groups—to enhance outreach efforts to potential Medicare Savings Programs' beneficiaries by reaching a broader slice of the population. These partnerships use each partner's strengths, e.g., the Medicaid agency's expertise with the programs, the advocate's familiarity with the low-income elderly and individuals with a disability whom the Medicaid agency would like to attract, or the health care delivery system's access to those who may be struggling with their medical costs.

Other State Agencies

States are most likely to look first to other state agencies for partnership opportunities. Common partners include State Units on Aging, Area Agencies on Aging, and State Health Insurance Assistance Programs (SHIPs), all of which offer significant expertise on and contact opportunities with senior citizens. States also partner with Income Maintenance Divisions, and, less frequently, Insurance Departments and the State Children's Health Insurance Program (SCHIP). There were also other state agencies listed as partners.

A statewide task force focusing on increasing participation in the Medicare Savings Programs is another major partnership effort underway in at least twenty-one states. Much like the federal-state initiative, this project brings together a variety of diverse agencies, community groups, providers, and advocates to plot how best to educate and attract the target population. No two states design their task force the same way. Some of the task forces are ongoing and others have set endpoints. They may work on such varied issues as advancing dual eligible outreach, improving service delivery, enhancing training materials, potential computer system changes, and data exchange or they may be more focused, working specifically to study, for example, a proposed self-declarative redetermination form. Task force member organizations generally share print outreach materials and training modules and strive to use common terminology.

Federal Agencies

While CMS and SSA are the most obvious and best used sources for partnership efforts, states also report relationships with the Health Resources and Services Administration (HRSA), Medicare fiscal intermediaries, the Department of Veterans' Affairs (VA), the Department of Housing and Urban Development (HUD) housing projects, and the Indian

Health Service (IHS). States have also taken increased advantage of funding and other resources offered by various federal government agencies since our 1998 survey.

County/City Government

At least fifteen states have reached out to county or city governments to increase Medicare Savings Programs participation. States report that by encouraging their local governments to get involved in the campaign to enroll more eligibles in the Medicare Savings Programs, they often come up with inventive ideas for program attendance at local events that provide a broad range of information of benefit to seniors.

Health Care Delivery Community

While seventeen states reported they partnered with their health care delivery community in 1998, almost twice as many did in FFY 2000. The most common of these partnerships involved community health centers and hospitals, though some states also have connections to Medicaid or Medicare managed care organizations, pharmacy benefit managers, and, to a much lesser extent, vision specialists, or providers.

Advocates and Grass Roots Organizations

Finally, thirty-six states report partnerships with various advocacy and grass roots organizations, and twelve specifically with legal assistance. Religious affiliations account for partnerships in at least sixteen states and volunteers—either "senior" or otherwise—promote the Medicare Savings Programs in about half of the states. States find that foundations and advocacy organizations are a welcome source of funding for Medicare Savings Programs' outreach efforts.

Part III: Dual-Eligible Specific Application, Enrollment, and Eligibility Process

*For state specific data on application, enrollment, and eligibility, please see the tables in the appendix of this report.

In an effort to make the Medicare Savings Programs' application and enrollment process less time consuming and confusing, states have taken major steps toward simplification on behalf of the beneficiaries since our 1998 report.

Application Form and Process

Thirty-three states have made a shorter application form than that used for full Medicaid available for applicants interested in the Medicare Savings Programs in hopes that this will ease the stress involved with applying for the programs. Three states are currently running pilot projects with shortened applications for the Medicare Savings Programs and five more states have concrete plans to develop the shortened applications. In at least two of the remaining states, the Medicaid application is already very short. Thus, roughly 80% of the states have made a commitment to shortening the application form for the Medicare Savings Programs, a remarkable increase from the 24% of states that used short applications in late 1998.

In addition, states have made a concerted effort to eliminate the welfare stigma attached to visiting the county social service office. The vast majority of states require neither pick up nor delivery of Medicare Savings Programs' applications in-person at the social service office, allowing instead for alternative methods such as mail-in applications or receiving applications at sites such as providers' offices or community organizations. To a lesser extent, states use the phone, fax, or internet to distribute blank applications or receive completed ones.

States have also made a concentrated effort to allow applicants to apply for the Medicare Savings Programs without requiring an in-person interview. Only seven states currently maintain this requirement, though one of these states plans to lift it by December 2001 and another is running a pilot program to consider removing the in-person interview requirement. Two other states require in-person interviews for QMB applicants only; SLMBs and QIs do not have to appear in person. The forty-two states that do not require face-to-face interviews for this population represent a significant improvement from twenty-nine states in 1998.

Eligibility Determination

By simplifying the application form and process, states automatically make the eligibility determination process more user-friendly. States may choose to go even further and allow self-declaration of income and resources; in states that choose to, applicants for Medicare Savings Programs' benefits are not required to bring in proof of their income or resources, but simply attest to their levels. Self-declaration of income and assets is used by eleven states, up from three states for income and eight states for assets, in our 1998 survey.

States that had taken advantage of the flexibility given to them through section 1902(r)(2) of the Medicaid statute—a section that allows states to use less restrictive methodologies to expand eligibility for the Medicare Savings Programs—continue to apply these liberalized methodologies used to count applicants' income and resources. There does not seem to be a significant shift in this group of states, most likely due to the need to gain state legislative approval for such a change.

In order to ensure they are adequately capturing the potential population for these programs, thirty-eight states automatically screen eligibility for the Medicare Savings Programs when beneficiaries apply for other state-administered benefits (e.g. prescription drug program, state-funded home care).

Redetermination Process

While analysts often concentrate on the measures states take to simplify the initial eligibility process for the Medicare Savings Programs, the redetermination process is just as significant. Without an efficient and comprehensible redetermination process, Medicare Savings Programs' enrollees may inadvertently fall off the rolls. Thus, it is heartening to report that over half of the states have automatic redetermination processes in place for this population. Very few states require an in-person interview at redetermination. Thirty-eight states use a shortened application during the

redetermination process and ten of the remaining states began with a very short application.

In addition, at least one state reported a change in terminology surrounding the automatic redetermination process. In North Carolina, redetermination for this population is referred to as "re-enrollment." A "re-determination" would occur when an applicant is denied eligibility and appeals.

Conclusion

Having reviewed state-specific progress toward increasing interest and enrollment in the Medicare Savings Programs, we conclude that state Medicaid agencies, in conjunction with their partners and CMS, have invested much time and effort in reviewing their administration of these programs. The evidence is telling; states recognize the importance of the Medicare Savings Programs in protecting the low-income elderly and individuals with a disability and have translated that recognition into endeavors designed to directly combat the most commonly noted barriers, specifically lack of knowledge and understanding about the programs and their benefits, the stigma associated with a benefit administered by Medicaid ("welfare"), and the lengthy, complex application forms.

In fact, based on the data gathered in this survey, the following findings are the most striking in light of the focus on removing barriers:

- To combat the potential lack of knowledge about the programs, around 90% of states focus attention on educating potential beneficiaries and those who have an influence on them through print and/or broadcast outreach materials.
- To increase understanding of the noteworthy benefits offered by the programs and clarify any lasting misconceptions about rules, over 70% of states spend considerable resources educating not only potential beneficiaries, but also their own staff.
- By having state and local partners assist in the outreach and enrollment process, almost every state has worked to eliminate welfare stigmatism and simplify the Medicare Savings Programs' enrollment processes.
- To battle the "welfare stigma," the vast majority of states have eliminated the need for applicants to visit the county social service office at any time during the eligibility and enrollment process by increasing the venues for application take-up and decreasing the incidence of in-person interviews.
- To simplify paperwork associated with the Medicare Savings programs, over 80% of states use a shortened application form (the most dramatic shift in data collected by this survey) and an equally impressive number have made the redetermination process more streamlined.

These changes are heartening, representing the states' continuing commitment to finding and enrolling all those eligible for the Medicare Savings Programs.

APPENDIX

Types of Printed Outreach Material Options Used by State

	Letters					Pamphlets	Posters	Newspaper notices
	Beneficiaries	CHCs	Providers	Family	Flyers			
AL	●		●	●				
AK	●	●	●	●		●		
AZ				●		●	●	●
AR								
CA								
CO	●					●	●	
CT	●	●	●			●		
DE	●	●	●					
DC	●							
FL						●		●
GA						●		●
HI					●	●	●	
ID						●		
IL						●		
IN						●	●	●
IA	●					●		
KS						●	●	
KY								
LA		●	●			●	●	
ME	●	●	●	●	●	●	●	●
MD	●					●	●	
MA						●		
MI	●					●		●
MN	●	●	●	●	●	●	●	●
MS	●					●		
MO	●			●		●	●	
MT						●		●
NE	●					●	●	
NV						●	●	
NH	●	●	●	●		●	●	●
NJ	●							
NM	●							
NY			●					
NC						●		
ND	●							
OH	●	●				(●)[2]		
OK								
OR							●	
PA	●							
RI	●					●		
SC	●					●		
SD	●	●	●	●	●	●	●	●
TN								
TX	●					●	●	●
UT	●					●		
VT	●	●	●	●				
VA						●	●	
WA	●					●		
WV	●	●	●					
WI		●	●					
WY	●	●	●	●	●	●	●	
Total	29	13	14	10	5	34	18	11

[2] Parentheses indicate "in development, to be implemented"

Types of Broadcast Outreach Options Used by State

	Talk show	Radio PSA	Television PSA	Paid commercial	Local cable access
AL					
AK					
AZ		●		●	
AR					
CA					
CO					
CT	●				●
DE	●	●		●	
DC					
FL					
GA		●			
HI					
ID					
IL					
IN		●			
IA					
KS					
KY					
LA	●	●	●		
ME	●	●	●	●	●
MD		(●)[3]	(●)		
MA	●				
MI	●	●			
MN	●	●	●		●
MS	●				
MO					
MT	●				
NE	●				
NV					
NH	●				
NJ					
NM					
NY	●				
NC					
ND					
OH					
OK					
OR					
PA					
RI					
SC					
SD	●				●
TN					
TX	●	●		●	
UT		(●)			
VT		●	●		
VA					
WA					
WV					
WI					
WY		●			
Total	14	13	5	4	4

[3] Parentheses indicate "in development, to be implemented"

Types of Educational Outreach Options Used by State

	Live presentations				Phone hotline	Web page	Training	Target minority/special populations
	Health fairs	Small groups	One on one	Door to door				
AL	●	●				●	●	
AK							●	
AZ	●	●	●		●	●	●	●
AR								
CA		●	●				●	
CO	●		●					
CT	●	●			●	●	●	●
DE	●	●					●	●
DC	●	●	●					
FL							●	●
GA	●				●		●	●
HI	●	●			●		●	
ID								
IL	●		●			●	●	
IN	●	●	●			●	●	●
IA							●	
KS	●	●	●	●		(●)[4]	●	●
KY								
LA	●	●			●	●		
ME	●	●	●	●		●	●	●
MD		●	●					●
MA	●					●	●	
MI	●	●	●			(●)	●	●
MN	●	●	●		●	●	●	●
MS	●	●			◙[5]	●	●	●
MO	●	●	●		◙	(●)	●	●
MT	●	●	●		◙		●	●
NE					●		●	
NV		●	●					
NH	●	●	●				●	●
NJ	●	●	●		◙	●	●	
NM	●		●		●	●	●	●
NY	●	●	●			●	●	
NC		●	●					
ND		●	●				●	
OH	●	●	●			●	●	
OK								
OR								
PA	●				◙	●	●	●
RI	●	●	●					●
SC	●	●	●		●			●
SD	●		●		●	●	●	●
TN								
TX	●	●	●		●	●	●	●
UT	●	●	●			●	●	●
VT	●		●		◙		●	
VA						●	●	
WA	●				●	(●)	●	
WV		●						
WI	●	●						
WY	●	●	●		●	●	●	●
Total	34	31	28	2	19	24	35	23

[4] Parentheses indicate "in development, to be implemented"

[5] "◙" indicates a hotline that gives information on the Medicare Savings Programs, but is not dedicated solely to that purpose

State Agency Partnerships by State

	Area Agencies on Aging	SHIPs[6]	Income Maintenance Departments	Insurance Commissions	SCHIP[7]	Other	Statewide task force
AL	●						
AK	●						
AZ	●						●
AR	●						
CA	●						
CO	●						
CT	●						●
DE		●			●	●	
DC	●	●	●				
FL	●	●	●			●	●
GA	●	●	●		●		
HI	●						
ID	●						
IL	●	●	●		●		●
IN	●	●		●	●	●	●
IA	●	●			●		
KS	●						●
KY	●	●	●	●		●	
LA	●	●		●	●	●	
ME	●	●	●	●	●	●	●
MD	●						●
MA	●	●		●			●
MI	●						●
MN	●						
MS	●				●		
MO	●	●				●	
MT	●	●	●	●	●	●	●
NE	●	●					
NV		●				●	
NH	●	●	●	●		●	●
NJ	●	●			●		
NM	●	●	●		●	●	
NY	●	●		●	●		●
NC	●						
ND	●						●
OH		●					●
OK							
OR							
PA	●						
RI		●	●		●	●	●
SC	●	●					
SD	●	●	●	●	●	●	
TN	●	●					
TX	●	●				●	●
UT	●	●	●		●	●	
VT	●	●	●	●			
VA	●		●	●		●	●
WA	●	●	●	●			●
WV		●					
WI			●				●
WY	●	●	●	●	●		●
Total	43	30	17	13	16	16	21

[6] State Health Insurance Assistance Program
[7] State Children's Health Insurance Program

Other Government Partnerships by State

	CMS	SSA	HRSA	Medicare fiscal intermediary	VA	HUD	IHS	City/ county government
AL		●		●				
AK	●	●					●	
AZ	●	●	●				●	●
AR		●						
CA	●	●						
CO	●	●	●	●	●	●		
CT	●	●		●		●		
DE		●			●	●		
DC								●
FL		●	●					
GA	●							
HI	●	●				●		●
ID	●							
IL	●							
IN	●	●		●		●		●
IA	●							
KS	●	●			●		●	
KY	●			●				
LA	●	●						●
ME	●	●	●	●	●	●	●	●
MD	●	●	●		●			●
MA		●						
MI	●	●					●	●
MN	●	●	●	●		●	●	●
MS							●	
MO	●	●						
MT	●	●		●				
NE	●	●						
NV							●	
NH	●	●		●		●		●
NJ	●							●
NM		●					●	
NY	●	●		●	●			●
NC		●						
ND	●	●	●	●			●	
OH								
OK								
OR								
PA	●	●						
RI	●			●		●		
SC								
SD	●	●			●	●	●	●
TN	●	●						
TX	●	●		● (developing)				
UT	●	●			●			●
VT	●	●						
VA	●	●						
WA	●	●	●				●	●
WV	●							
WI								
WY	●	●		●	●			
Total	36	35	8	14	9	10	12	15

Health Care Delivery System Partnerships by State

	CHCs	Hospitals	Medicaid MCOs	Medicare MCOs	Providers	Pharmacy Benefit Managers	Vision Specialists
AL					●		
AK							
AZ	●	●					
AR	●						
CA							
CO	●		●	●			
CT	●	●		●			
DE		●		●		●	
DC			●				
FL	●				●		
GA							
HI	●	●					
ID							
IL							
IN	●	●	●	●	●		
IA							
KS	●	●		●			
KY		●				●	
LA	●	●	●	●			
ME	●	●		●			●
MD	●		●	●			
MA		●	●	●			
MI	●						
MN						●	
MS							
MO	●	●		●			
MT	●			●			
NE							
NV							
NH	●	●				●	
NJ							
NM							
NY							
NC							
ND	●						
OH	●						
OK							
OR							
PA							
RI	●	●					
SC							
SD	●	●					
TN							
TX							
UT	●	●					
VT	●	●				●	
VA							
WA	●						
WV							
WI							
WY		●				●	●
Total	22	17	6	11	3	6	2

Advocates and Grass Roots Partnerships by State

	Advocates	Legal assistance	Religious affiliations	"Senior" volunteers	Other volunteers
AL	●		●	●	●
AK					
AZ	●			●	●
AR	●				
CA	●				
CO				●	
CT	●	●		●	
DE			●	●	
DC	●		●	●	
FL	●	●			
GA	●	●	●		
HI	●		●	●	●
ID					●
IL	●		●	●	●
IN	●		●	●	●
IA				●	
KS	●			●	●
KY		●	●	●	●
LA	●		●	●	●
ME	●	●	●	●	●
MD	●		●	●	●
MA					
MI	●			●	●
MN	●	●	●	●	●
MS	●				
MO	●	●			
MT	●			●	●
NE	●				
NV	●		●		
NH	●	●		●	●
NJ					
NM	●			●	
NY	●	●		●	
NC	●			●	
ND	●				
OH					
OK					
OR	●				
PA	●				●
RI					
SC					
SD	●		●		
TN		●			
TX	●	●			
UT					
VT	●	●			
VA					
WA	●				●
WV	●				
WI	●				
WY	●			●	
Total	36	12	14	23	17

Application Form Length and Acceptance Sites Options by State[8]

	Shorter form available for dual eligibles	Mail	Providers/ Community	Internet	Phone	Fax	In-person interview not required
AL	●	● ◙	● ◙	●			●
AK		● ◙	● ◙			◙	
AZ	●	● ◙	● ◙	●		◙	●
AR	●	● ◙	● ◙				●
CA	●	● ◙	● ◙			◙	●
CO	● pilot	● ◙	● ◙		◙	◙	●
CT	●	● ◙	● ◙	●		◙	●
DE	●	● ◙	● ◙		◙	◙	●
DC	●	● ◙	● ◙			◙	●
FL	● pilot	● ◙	● ◙				● (pilot)
GA	●	● ◙	● ◙	●		◙	●
HI	(●)[9]	● ◙	● ◙			◙	●
ID		● ◙	●	● ◙		◙	●
IL	●	● ◙	● ◙				●
IN	●	● ◙	● ◙		◙	◙	●
IA		● ◙	●			◙	
KS	●	● ◙	● ◙		◙	◙	●
KY	●	● ◙					●
LA	●	● ◙	● ◙	● ◙	◙	◙	●
ME	●	● ◙	● ◙	●		◙	●
MD	●	● ◙	● ◙			◙	
MA	●	● ◙	● ◙			◙	●
MI	(●)	● ◙	● ◙				●
MN	(●)	● ◙	● ◙	● ◙		◙	●
MS		● ◙	● ◙	●		◙	●
MO	●	● ◙	● ◙	(considering)		◙	●
MT	●	● ◙	● ◙			◙	●
NE	●	● ◙	● ◙	◙	◙	◙	● (SLMB, QI only)
NV		● ◙	● ◙	●		◙	●
NH	●	● ◙	●		◙		●
NJ	●	● ◙	● ◙				● (SLMB, QI only)
NM	●	● ◙	● ◙			◙	●
NY	●	● ◙	● ◙				
NC	● pilot		●				
ND	(●)	● ◙	● ◙				●
OH	●	● ◙	● ◙	● ◙		◙	●
OK		● ◙	● ◙				●
OR	●	● ◙					●
PA	●	● ◙	● ◙	●			●
RI	●	● ◙	● ◙				●
SC	●	● ◙	● ◙				●
SD	●	● ◙	● ◙		◙	◙	●
TN	●	● ◙			◙	◙	●
TX	●	● ◙	● ◙	●		◙	●
UT	Already short	● ◙	● ◙		◙	◙	●
VT	●	● ◙	● ◙	●			●
VA		● ◙					●
WA	●	● ◙	● ◙	● ◙		◙	●
WV	●	● ◙	● ◙			◙	●
WI	(●)	(●)(◙)	◙				(●)
WY	Already short	●	●		◙		●
Total	43	50●, 49◙	46●, 43◙	15●, 6◙	11	31	46

[8] "●" means available, "◙"means accepted

[9] Parentheses indicate "in development, to be implemented"

Eligibility Determination Process Options by State

	Self-declaration of income/resources	Income test liberalized	Resource test liberalized	Automatic eligibility screen for QMB/SLMB
AL			●	●
AK				●
AZ		●	●	●
AR	(●)[10]		●	●
CA				
CO				
CT	●	●		●
DE			●	●
DC				●
FL	● (pilot)	●	●	●
GA	●	●		
HI				●
ID				
IL	●			●
IN				●
IA				
KS		●	●	●
KY				
LA				
ME				●
MD				●
MA	●			●
MI				●
MN	●[11]		●	●
MS		●	●	●
MO				●
MT				●
NE				●
NV				
NH				●
NJ				
NM	●			●
NY				
NC				
ND		●	●	●
OH				●
OK				●
OR				●
PA				●
RI	●			●
SC				
SD		●		●
TN	●	●	●	
TX	●			●
UT				●
VT	●	●		●
VA				●
WA		(●)	(●)	●
WV	●	●	●	●
WI				●
WY				●
Total	13	12	12	38

[10] Parentheses indicate "in development, to be implemented"

[11] Income must be verified through delayed verification program during which benefits may be received.

Eligibility Redetermination Options by State

	Automatic	In-person interview not required	Shortened application at redetermination
AL	●	●	●
AK			●
AZ	●	●	●
AR	●	●	Full application, but already short
CA		●	●
CO	●	●	●
CT		●	●
DE	●	●	●
DC		●	●
FL	●		Full application, but already short
GA	●	●	●
HI		●	
ID	●	●	Full application, but already short
IL	●		Full application, but already short
IN	●	●	Full application, but already short
IA	●		●
KS	●[12]	●	Full application, but already short
KY		●	●
LA		●	●
ME	●		Full application, but already short
MD		●	●
MA		●	●
MI			● (nursing facilities only)
MN	●	●	●
MS		●	●
MO	●	●	●
MT	●	●	●
NE			●
NV	●	●	●
NH	●	●	●
NJ	●	●	●
NM		●	●
NY		● (only QIs)	●
NC		●	●
ND	●	●	●
OH		●	●
OK			●
OR		●	Full application, but already short
PA		●	●
RI	●	●	●
SC		●	●
SD	●	●	●
TN	●	●	Full application, but already short
TX		●	●
UT	●	●	●
VT	●	●	
VA		●	
WA			●
WV	●	●	●
WI		●	●
WY	●	●	Full application, but already short
Total	27	42	48

[12] Except for QI-2s.

[State Name] Application for Medicare Savings Programs for Beneficiaries (Dual Eligibles)

1. INSTRUCTIONS:

These programs may help pay all or part of your Medicare costs. However, this is **NOT** an application for full Medicaid, cash assistance, or food stamps. If you want to apply for these programs, contact your county department of human services. This application **CAN** be used for a single person or a couple (self and spouse). Read the application carefully and follow all instructions given throughout the form.

1. Answer each question the best you can. Attach additional pages if needed.
2. Include copies of all documents. **Do not send original documents.**
3. **Sign and date the application.**
4. Mail the application to:

5. An interview in-person is not required for these Medicare Savings Programs.

AGENCY USE ONLY

Case No. _____

Date Received _____

Date Registered _____

Worker _____

2. PERSONAL INFORMATION:

Name (First, Middle Initial, Last)	**You may have a friend, relative, or someone else help you complete this application. If someone else is completing this form, provide the following information for the individual completing the form.**
Birthdate Sex Race Marital Status	
Social Security Number U.S. Citizen ☐Yes ☐No	Name (First, Middle Initial, Last)
Street Address	Street Address
City State Zip	City State Zip
Phone County	Phone
Nursing Facility (if applicable)	Relationship to Individual

3. INFORMATION ON SPOUSE: Complete this information even if not applying for spouse.

Spouse's Name	Birthdate	Sex	Race	U.S. Citizen	Social Security Number (Optional, if spouse is not applying.)
				☐Yes ☐No	
Address of Spouse if Different from Applicant:					
Are you applying for Medicare savings for your spouse, too? ☐Yes ☐No					

4. LIVING ARRANGEMENT: Check the one box (☐) that describes current living situation.

	Own Home	Renting	Nursing Facility	In Other's Home	Hospital	Other (example: shelter)
Self	☐	☐	Date Admitted:	☐	Date Admitted:	Describe:
Spouse	☐	☐	Date Admitted:	☐	Date Admitted:	Describe:

5. INCOME AND EARNINGS:

List all types of earnings and income that you or your spouse receive. List the income amount before deductions (such as taxes or insurance) are taken out. Include proof of all income (check stub, benefit letter, etc.), **do not send original documents**. Examples of income include:

* Social Security
* SSI
* Wages/ Self-Employment
* Railroad Retirement Benefits
* Veterans' Benefits
* Trust or Annuity Payments
* Pensions/ Retirement Benefits
* Rental Income
* Oil Royalties/ Mineral Rights

Who Receives Income (Name)?	Type of Income	Employer or Source of Income	Amount	How Often Received?	ID Number (if applicable)

6. RESOURCES:

Do you or your spouse own or co-own any of the following? Include any accounts or properties on which you or your spouse's name(s) appear. Include verification (such as **copies, not originals**, of past 3 bank statements, trust funds, etc.) of all resources.

Do you, or your spouse, have any of the following resources?

Checking account	☐Yes	☐No	Funeral plans/ burial arrangements	☐Yes	☐No
Savings account	☐Yes	☐No	Burial plots	☐Yes	☐No
Government bonds	☐Yes	☐No	Stocks and bonds	☐Yes	☐No
Trust funds	☐Yes	☐No	Certificate of Deposits	☐Yes	☐No
Savings Bonds	☐Yes	☐No	Other (e.g. IRAs, etc.)	☐Yes	☐No

If you answered yes to any of these questions, describe below. Attach additional pages if necessary.

Type of Resource	Account/ Policy Number	Value	Name of Bank, Insurance Company, Etc.

7. LIFE INSURANCE:

Do you, or your spouse, have a life insurance policy? ☐Yes ☐No

If yes, please complete the following information and attach a **copy** of the policy:

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

8. PROPERTY:

Do you own all or part of any real estate in which you do not live? ☐**Yes** ☐**No**

If yes, please complete the following for each piece of real estate and attach proof **(copies)** of ownership and current value. **Do not list the house in which you live.**

Address	Value	Amount Owed

Do you, or your spouse, own or co-own a car, truck, motorcycle, boat, trailer, or other vehicle? ☐**Yes** ☐**No**

If yes, please complete the following information about each vehicle:

Owner(s)	Year	Make	Model	Value	Amount Owed

9. INFORMATION ON MEDICARE:

Attach **copies** (front and back) of Medicare card(s) if you, or your spouse, have Medicare.

Do you have Medicare? ☐Yes ☐No	Type of Coverage **(Check Each Box that Applies)** ☐ Part A ☐ Part B	Effective Date	Medicare ID Number
Does your spouse have Medicare? ☐Yes ☐No	Type of Coverage **(Check Each Box that Applies)** ☐ Part A ☐ Part B	Effective Date	Medicare ID Number

10. INFORMATION ON OTHER INSURANCE:

Do you have other health insurance? ☐**Yes** ☐**No**

Does your spouse have other health insurance? ☐**Yes** ☐**No**

If you, or your spouse, have other insurance, please complete the following information and attach a **copy** (front and back) of insurance card(s):

	Health Insurance Company Name **and** Company Address	Annual Premium	Type of Coverage (Hospital, Medigap, RX)	Effective Date	ID Number
Self		$			
Spouse		$			

PRIVACY STATEMENT:

Federal and state laws and regulations limit the use and disclosure of confidential information concerning applicants and recipients of all agency programs to purposes directly related to the administration of these programs.

ASSIGNMENT OF RIGHTS OF PAYMENT FOR MEDICAL SUPPORT AND OTHER MEDICAL CARE:

(If you are applying on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described below, as a condition of his or her eligibility for the benefits covered by this application.) As a condition of my eligibility, I assign to the state any rights to medical support and to payment for medical care from any third party. I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days.

APPLICANT'S STATEMENT OF UNDERSTANDING AND AGREEMENT:

I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility by state and/or federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records. I also agree that my application authorizes these agencies to release to this agency the information needed to determine my eligibility. I agree to provide the documents necessary to establish eligibility. If documents are not available, I agree to give the name of the person or organization from which this agency may obtain the necessary proof.

I understand that each individual who receives assistance must provide or apply for a Social Security Number. I authorize the use of my (our) Social Security Number for such purposes as identification, program reviews or audits, and computer matching with other agencies and institutions such as banks, saving and loan associations, and other government agencies, including Internal Revenue Service, to verify eligibility for assistance.

I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I understand that I may request a fair hearing if I disagree with an agency decision in my case and that I may be represented by any person I choose.

I certify that I (or if filing for my spouse, my spouse and I) am a U.S. citizen, national, or alien in qualified alien status. If this application is being filed on behalf of another individual or individuals, the actual applicant(s) will need to make this certification.

APPLICANT(S) OR REPRESENTATIVE MUST READ AND SIGN:

State and federal law provide for fine, imprisonment, or both for any person who withholds or gives false information to obtain assistance to which he is not entitled. I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge. I agree to notify this agency of changes in my income, resources, or living arrangements, which might affect my right to receive assistance.

Signature of Applicant or Representative:	**Date:**
Signature of Applicant's Spouse:	**Date:**