

Contract No.: 500-00-0003
MPR Reference No.: 6199-430

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**Final Evaluation Report:
Best Practices for
Enrolling Low-Income
Beneficiaries into the
Medicare Prescription
Drug Benefit Program**

Final Report

February 16, 2009

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Submitted to:

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ACKNOWLEDGMENTS

The authors thank Noemi Rudolph, Centers for Medicare & Medicaid Services (CMS) Project Officer, for her important guidance throughout the study, and express appreciation as well to the many CMS staff members who provided valuable comments on earlier project reports upon which this evaluation is based and who provided comments on this report itself.

The authors further acknowledge the contributions of current or former colleagues at Mathematica Policy Research, Inc. (MPR), who authored the earlier project reports: Leslie Foster, Beth Stevens, Allison Barrett, Whitney Schott, Jim Verdier, Debra Lipson, Rhoda Cohen, Su Liu, and Nora Paxton. Leslie Foster, in particular, contributed substantially to this report as the former project director at MPR for most of the study. Beth Stevens also provided insightful comments on an earlier draft of this report. Others who made important contributions include Amanda Bernhardt, who edited the document, and Jackie McGee and Alfreda Holmes, who produced it.

Finally, we thank Marisa Scala-Foley, Kristen Kiefer, and Brandy Harris of the National Council on Aging, who contributed valuable advice to MPR throughout this study, endeavored to assign comparative cost-effectiveness values to best practices, and provided helpful comments on an earlier draft of this report.

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EXECUTIVE SUMMARY

A. INTRODUCTION

Beginning in January 2006, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) significantly expanded the Medicare program by adding optional coverage for outpatient prescription drugs (Medicare Part D). The MMA also established a low-income subsidy program (LIS) to help Medicare beneficiaries with limited incomes pay for Part D out-of-pocket expenses. Because many public benefit programs have historically experienced low enrollment, Congress included specific provisions in the MMA to help lower barriers to applying for and enrolling in the Part D and LIS programs. The MMA also required the secretary of the U.S. Department of Health and Human Services (DHHS) (with the Centers for Medicare & Medicaid Services (CMS) acting as its agent) to report to Congress on “best practices in the successful enrollment of low-income beneficiaries” into these programs. CMS contracted with Mathematica Policy Research, Inc. (MPR), to conduct a three-year study of best practices to help the agency develop its report to Congress. This report summarizes key findings from our study, designed to investigate the following research areas:

1. The foremost research goal was to identify which of the many activities conducted by national, regional, state, and local organizations during the first and second years of the Part D and LIS programs appeared to be most effective for enrolling low-income beneficiaries into these new programs—that is, what were “best practices.”
2. A secondary goal was identifying the main challenges that low-income beneficiaries faced in applying to LIS and selecting a Part D prescription drug plan. This research area helped us focus attention on practices that effectively addressed those challenges.
3. Also of secondary importance—but fundamental to identifying best practices—was a comprehensive survey of national, regional, state, and local organizational efforts in the first and second program years to raise awareness and understanding of the new programs and to assist low-income beneficiaries with LIS application and drug plan selection.
4. Identifying significant changes in outreach, education, application assistance, and decision support practices from the first Part D benefit year to the second—and the reasons for these changes—sharpened focus on which practices suitable for the first program year of very high demand for assistance would continue to be best practices in the second year as requests for help leveled off and new program issues arose.
5. Finally, we examined the ease with which “best practices” identified during the study might be replicated, disseminated, expanded, or sustained in coming years.

We gathered qualitative data from four sources to address the study’s areas of inquiry:¹ (1) telephone interviews from May through July 2006 with 30 stakeholders and independent experts responsible for or familiar with the overall design and implementation of Part D/LIS outreach, education, and enrollment strategies in the nation, states, and local communities, and another set of similar telephone interviews in March and April 2007 with 20 such organizations; (2) a mail survey of each state Medicaid office, State Health Insurance Assistance Program (SHIP), and State Pharmaceutical Assistance Program (SPAP) in the 50 states and the District of Columbia about their Part D and LIS activities in fall/winter 2006; (3) a case study of promising practices in six sites across the U.S. in summer 2007;² and (4) two sets of focus groups (conducted in fall 2006 and fall 2007) with low-income deemed, formerly deemed, non-deemed Medicare beneficiaries, and non-deemed LIS applicants,³ “information intermediaries”⁴ who assisted beneficiaries with LIS applications and Part D plan choice, and health care providers (pharmacists, physicians, nursing home administrators, and family caregivers of nursing home residents).

The qualitative data served several purposes: to identify best practices by surveying numerous people actively engaged on a daily basis in supporting low-income beneficiaries with understanding and enrolling in the new Part D program; to uncover details about what makes best practices more or less effective; to understand why some best practices were continued and some were not into the second year of the Part D and LIS programs; and to allow people to express both their accomplishments and their frustrations with various elements of the programs and assistance activities.

B. WHAT WERE BEST PRACTICES FOR ENROLLING LOW-INCOME BENEFICIARIES IN PART D AND LIS?

Two years of intense experience providing outreach, education, and assistance to low-income Medicare beneficiaries for the Part D and LIS programs gave study participants a solid sense of what worked well. We were able to identify which of the practices seemed most effective across all situations and populations by asking participants to think of “best practices”

¹ Appendix A provides brief descriptions of the data sources. Lists of respondents and research tools used in the study are available from CMS upon request.

² The six sites were Maine, metropolitan Atlanta, greater Cleveland, the Chicago suburbs, southern New Mexico, and Idaho.

³ Deemed status refers to beneficiaries who automatically qualify for LIS subsidies because they are dually eligible for Medicare and Medicaid benefits, participate in the Medicare Savings Programs, or receive Supplemental Security Income. Non-deemed individuals are low-income beneficiaries who must actively apply for LIS benefits through the Social Security Administration (SSA) or their state Medicaid office; non-deemed LIS applicants are beneficiaries who applied for and were determined qualified to receive LIS benefits.

⁴ “Information intermediaries” refers to both formal intermediaries (including SHIPs, Area Agencies on Aging [AAAs], and local SSA offices) and informal intermediaries (including people who serve low-income Medicare beneficiaries through their work at senior centers, advocacy groups, volunteer organizations, senior housing complexes, ethnic membership organizations, and other such community-based organizations).

in terms of activities or processes that seemed to be most appropriate and effective in identifying, reaching, educating and enrolling a given population in a particular setting.

Although respondents from all of our data collection activities candidly shared their opinions about activities that seemed to work well—or not very well—during the first and second years of the Part D and LIS programs, none could substantiate his or her observations with firm evidence of success or failure. Under a subcontract with the National Council on Aging (NCOA), we attempted to collect quantitative comparative cost-effectiveness information on LIS outreach and assistance activities from our case study sites. However, we were ultimately unable to make robust cost-effectiveness comparisons among activities or across sites due to the sizeable challenges involved in collecting retrospective data and in attempting to measure effectiveness and costs in the presence of substantial differences in coalition structures, formal partnerships, and supporting infrastructure across sites.⁵ Therefore, the best practices described in this report reflect respondents' observations about practices that seem to be succeeding in the field, as corroborated through our four types of qualitative data collection activities.

Participants from our state survey, focus groups, expert/stakeholder interviews, and the case study consistently identified the following as best practices for each step of the process, from identifying potential individuals eligible for LIS application to Part D plan decision-making:

- ***Identification***

- Use high-quality lists of qualified leads to identify potential beneficiaries who must apply for LIS (so-called non-deemed individuals); in the absence of such lists, use local safety net provider lists and lists from other low-income public benefit programs
- Identify and educate beneficiaries by reaching out to them through their daily activities

- ***Outreach and Education***

- Tailor advertisements and messages to local markets and local media
- Time community outreach to coincide with activities already planned for seniors, people with disabilities, and low-income persons in general

⁵ CMS is planning to conduct a more controlled and limited cost-effectiveness analysis under its investigation into best practices for enrolling low-income beneficiaries into the LIS program. The first stage of the CMS research, currently underway, is an experimental study of factors influencing LIS enrollment using direct marketing approaches. The agency is evaluating the effectiveness of five direct marketing interventions (differing along a dimension of outreach intensity, including a control condition) on behavioral factors related to LIS enrollment. The analysis will also examine the effectiveness of refining CMS targeting lists using commercially-available household income prediction models in identifying beneficiaries whose income levels are consistent with LIS qualification criteria. The next stage of CMS' research will layer cost-effectiveness analyses onto the current study's findings.

- ***LIS Application Assistance and Part D Plan Decision Support***
 - Provide comprehensive personalized one-on-one assistance
 - Provide assistance through counselors that beneficiaries trust
 - Provide assistance in the beneficiary’s primary language

Below, we describe these seven best practices in greater detail.

1. Identification

Identify Beneficiaries Through Local Safety Net Provider and Public Benefit Program Lists. The absence of reliable lists of qualified leads from organizations such as CMS, the Social Security Administration (SSA), or state agencies was often cited by formal and informal information intermediaries as a problem.⁶ Partnerships with community-based organizations (CBOs)⁷ and local safety net health care providers were generally seen as the next best way to identify beneficiaries potentially eligible for LIS who must apply for these benefits. CBOs and health care providers sometimes maintain lists they cannot share with others but that they themselves can use to identify low-income beneficiaries. One of the most useful sources is safety-net providers (for instance, Community Health Centers, Federally Qualified Health Centers, and community hospitals).

Many study respondents said they also made excellent use of lists from other public benefit programs—such as the food stamp program; local or regional energy assistance programs; food pantries; Meals-on-Wheels; and health plans targeted to low-income, Medicaid, or special-needs individuals—that serve populations similar to the LIS population. State governments may have access to lists for programs funded or administered by the state, such as for the Low Income Home Energy Assistance Program (LIHEAP), property tax rebate programs, and SPAPs. AAAs often have good access to such lists because they generally administer a variety of programs for older adults, including employment services, senior centers, congregate meals, adult day care services, in-home services, senior housing, and legal assistance. Some AAAs also house SHIPs,

⁶ In general, an information intermediary is someone who can answer health care consumers’ questions, address concerns, and help them apply information on health care programs and benefits to their personal situations. “Informal intermediaries” in our study include the types of CBOs that many state and local government agencies partnered with to promote Part D and LIS enrollment: adult day centers, housing complexes for seniors or low-income residents, senior centers or senior services organizations, legal aid organizations for low-income persons, Centers for Independent Living (CIL) that provide services to people with physical or mental disabilities, and organizations that serve clients who belong to specific ethnic groups or have certain illnesses or chronic conditions. Health care providers (such as “safety-net” hospitals, FQHCs, primary care clinics, and retail pharmacies) also function as informal intermediaries for sharing Medicare information with beneficiaries and family caregivers. “Formal intermediaries” in our study refer to the type of CBOs that had clear responsibility and specific funding to help educate and enroll beneficiaries in Part D and LIS, and that also serve local communities. Formal intermediaries consist of locally based Medicaid, SSA, SHIP, and AAA offices.

⁷ We use the term CBOs in this report to include both formal and informal intermediaries serving a local geographic area, such as a group of counties, a single county, a city or town, or specific communities within a city or town.

making them a natural information intermediary for Part D and LIS assistance. It is sometimes difficult for one organization to obtain confidential lists from others, however. One remedy is to partner with another CBO in outreach efforts, such as by including information about LIS on printed Meals-on-Wheels menus or enclosing Part D flyers in utility statements. Another approach is to offer “one-stop shopping” assistance at one agency or location for a variety of public benefit, health, aging, and disability programs, including Part D and LIS.

Identify and Educate Beneficiaries by Reaching Out to Them Through Their Daily Activities. Many CBOs charged staff members or volunteers with identifying potential LIS-eligible individuals at sites and neighborhoods where low-income individuals typically congregate. The sites most often suggested were low-income housing complexes, food banks, grocery stores (on days popular with food stamp shoppers), faith-based organizations, and pharmacies (when free flu shots or blood pressure screenings were offered). Visits to these locations often proved more productive than conducting enrollment clinics at, for example, senior centers, which do not necessarily serve only low-income individuals.

2. Outreach and Education

Tailor Advertisements and Messages to Local Markets and Local Media. To increase beneficiary attentiveness and understanding of Part D and LIS education and outreach materials, messages should be customized to reflect the characteristics and preferences of the local community. Furthermore, we heard repeatedly that beneficiaries have greater trust in information delivered by local media—community or special-language newspapers, AM radio stations, and community-access cable television—than in messages appearing in national newspapers or on television networks, which are often perceived as “slick.”

Time Community Outreach to Coincide with Activities Already Planned for Seniors, People with Disabilities, and/or Low-Income Persons. A best practice approach to outreach and communications is to take advantage of scheduled local events. This might include, for example, conducting outreach at health fairs already organized by local senior centers or asking to be put on the agenda for a town hall meeting.

3. LIS Application Assistance and Part D Plan Decision Support

Provide Comprehensive Personalized One-on-One Assistance. Experts and stakeholders, formal and informal intermediaries, case study respondents, and beneficiaries themselves said comprehensive and personalized one-on-one assistance is by far the best way to enroll low-income beneficiaries in Part D plans and apply to LIS. Comprehensive assistance may consist of trained counselors who help beneficiaries complete a LIS application and then submit it to SSA for them, or help beneficiaries use the CMS Plan Finder or similar online tool and then submit the plan choice to CMS. Personalized assistance may require a counselor to modulate his or her voice for a beneficiary with a hearing impairment, to explain the LIS application to a suspicious beneficiary in order not to stir fears about the government’s interest in the beneficiary’s assets, or to remind a generally reluctant applicant about the importance of insurance against unforeseen needs. Study respondents also emphasized that telephone assistance may be as effective as in-person assistance as long as the person delivering help is knowledgeable and patient and the beneficiary does not have to navigate automated telephone systems.

Before the introduction of Part D, formal intermediaries such as the SHIPs and AAAs frequently relied heavily on volunteers to provide one-on-one assistance to Medicare beneficiaries. However, several SHIPs and AAAs said they now make much less use of volunteers. The consensus among respondents was that very few volunteers can understand and explain to others the complexities of the combination of Medicare Parts A, B, C, and D, as well as related issues such as Medigap plans, employer-sponsored drug coverage, SPAPs, commercially sponsored free prescription drug programs, Veteran Affairs' health benefits, and Medicaid and Medicare Savings Programs (MSP).

Use Trusted Counselors. Many low-income beneficiaries not only require personalized assistance, but must receive it from someone they trust. Applying for assistance means divulging personal information about income, assets, and prescription drug needs. An example: although CMS and SSA provide toll-free helplines, none of our case study sites referred beneficiaries to them (although staff at some CBOs said they sometimes call the helplines on behalf of beneficiaries) because beneficiaries are usually more comfortable disclosing financial and medical information to counselors they know or with whom they share a common trait. In addition, we frequently heard that beneficiaries respond best to messages and materials associated with organizations they trust.

Provide Assistance in the Beneficiary's Primary Language. Obtaining assistance in their primary language can be very important to beneficiaries. This finding is consistent with other studies that stress the importance of having outreach specialists who know the language or local dialect (Glaun 2002 and Hoover et al. 2002). CBOs that serve specific ethnic or immigrant communities often employ staff who can communicate in the beneficiary's preferred language or who can access low-cost translation or interpreter services. Some CBOs recruited bilingual community volunteers or students and professors from local colleges to assist non-English-speaking beneficiaries.

C. WHAT CROSS-CUTTING ELEMENTS ENHANCED THE EFFECTIVENESS OF BEST PRACTICES?

One of the most important findings that stands out across all of our research was that three fundamental elements improve the chances for any of the best practices respondents identified to be effective:

1. Strong reliance on CBOs to “do the heavy lifting” of reaching out to, educating, and providing one-on-one assistance to beneficiaries from trusted advisors
2. Establishment of a comprehensive infrastructure of broader-based organizations with a national focus (for example, CMS and Social Security Administration (SSA) central offices and advocacy organizations such as NCOA, Families USA and AARP), a regional focus (for example, CMS regional offices), or state focus (for example, Medicaid agencies, state aging departments, and state SHIP offices) to support CBO efforts
3. Formation of inclusive and cohesive formal and informal partnerships to create the necessary links among CBOs and between CBOs and broader-based organizations

Additional details on each of the three follow.

1. Rely on Community-Based Organizations to Implement Best Practices

An oft-repeated refrain from individuals and organizations participating in our research was that “working through CBOs” is one of the best ways to address many of the challenges to Part D plan enrollment or LIS application for low-income beneficiaries. Unlike agencies that cover a broader geography, CBOs (both formal and informal information intermediaries) generally succeed in arranging and performing outreach and enrollment activities *that are visible to or directly involve beneficiaries*. CBO success reflects two realities: (1) CBOs are often best situated geographically to provide the one-on-one assistance needed and desired by most beneficiaries; and (2) the most effective outreach and enrollment activities are often context-based and take advantage of the enabling infrastructure (such as assistance with strategy development and training), with which CBOs have more familiarity than broader-based organizations. CBOs may fulfill many roles in effective implementation of the best practices we identified, including at least the following:

- ***CBOs Can Identify Beneficiaries Through Public Benefit Program Lists.*** CBOs often maintain client lists they cannot share with others but that they themselves can use to identify low-income beneficiaries. Examples include information on Meals-on-Wheels clients, home health care clients, or residents of an adult community who receive subsidized housing.
- ***CBOs Can Identify and Educate Beneficiaries by Reaching Them During Their Daily Activities.*** CBOs often have considerable familiarity with the places where potentially eligible beneficiaries frequently gather, feel comfortable, and are likely to be receptive to learning about Part D and LIS. Moreover, CBOs typically know a great deal about their client base. For example, in a small town in New Mexico that we visited, we learned that Hispanic beneficiaries prefer one senior center and that white, non-Hispanic beneficiaries prefer another. A regional organization might host a bilingual information session at one or the other center, but a CBO familiar with the town’s seniors would recommend a session at each.
- ***CBOs Can Provide Insight into Strategies Most Likely to Work Locally.*** An example of CBO usefulness in helping design outreach and education strategies came from our Atlanta case study. Staff in the Atlanta site of Georgia’s SHIP (Atlanta GeorgiaCares) knew volunteers and beneficiaries would be reluctant to negotiate Atlanta’s traffic congestion and parking problems to travel to their downtown office, so their strategies relied heavily on a toll-free SHIP number to assist most beneficiaries.
- ***CBOs Can Help Tailor Advertisements and Messages to Local Markets and Local Media.*** CBOs can effectively tailor messages to their local community’s characteristics in ways broader-based organizations often cannot. For example, “extra help,” the term for the LIS benefit promoted by CMS and SSA, works very well in some areas. But in Maine, the Access to Benefits coalition approached the audience from the perspective of saving money for family events or for children or grandchildren. The coalition initially tried to use the “extra help” phrase, but found it

did not work with Mainers, who seem to be culturally opposed to accepting extra help and reluctant to take benefits from someone who may be more needy. Additionally, compared to broader-based organizations, CBOs can customize outreach materials and messages to reflect the characteristics and preferences of the community and often can obtain media time or space for reduced rates or for no charge at all.

- ***CBOs Can Time Community Outreach to Coincide with Activities Already Planned for Specific Beneficiary Populations.*** With sufficient resources, CBOs are well situated to pursue an “opportunistic” approach to outreach and communications, taking advantage of already scheduled local events. For example, on May 15, 2006, in Cleveland, Ohio—the last day of the enrollment period for that benefit year—Jesse Jackson addressed the congregation of Cleveland’s most prominent Baptist church at the invitation of the pastor. Jackson’s appearance received little advance publicity; in fact, the SSA public affairs specialist learned of the appearance that morning while listening to the radio. But immediately upon hearing Jackson would appear, the specialist contacted the church, which offered him the opportunity to speak about LIS to the congregation. With encouragement from the compelling Jackson, people apparently conquered their usual reluctance, and the SSA specialist had his most successful enrollment ever.
- ***CBOs Can Provide Comprehensive Personalized One-on-One Assistance Through a Trusted Counselor.*** All the local SSA offices and SHIPs we spoke with said partnering with CBOs that had already earned the trust of low-income Medicare beneficiaries was a very effective way to engage them. In addition, CBOs are often more easily reached on public transportation.

2. Develop Infrastructure of Broader-Based Organizations to Support CBOs in Implementing Best Practices

Another consideration in making practices work effectively for Part D and LIS beneficiaries involves developing a strong infrastructure—financial and non-financial—that can support CBO implementation of the best practices described above. Many CBOs lack the time, financial resources, or technical skills to work in isolation from organizations that cover a broader geography, and can make excellent use of strong partnerships with federal, state, and local government agencies; politicians; and aging and disability service organizations. Below, we describe the necessary building blocks of the infrastructure and identify the types of organizations best suited to each infrastructure component, according to our expert/stakeholder respondents, formal and informal intermediary focus group participants, and case study respondents. (Figure 1 organizes the components by the type of organization.)

FIGURE 1

TYPES OF ORGANIZATIONS INVOLVED IN OUTREACH AND ENROLLMENT,
AND THE TASKS EACH TYPE DOES BEST

Federal Agencies: Inform regional offices and state and city agencies about changes in eligibility requirements and enrollment periods. Develop high-quality lists of potential LIS-eligible individuals. Develop online application and enrollment tools. Fund national and state activities. Develop and disseminate outreach tool kits to state and city agencies that include informational materials that can be tailored to local circumstances. Notify beneficiaries of LIS status and plan enrollment.

Regional Offices of Federal Agencies: Train staff members in state and city agencies. Contribute to state- and city-level planning. Encourage regional press coverage. Promote information-sharing across states or other localities. Resolve complex cases and identify widespread problems.

National and State Advocacy Organizations: Advocate for changes in national and state policy when appropriate. Fund state and community activities. Develop informational materials and tools that can be tailored to local circumstances.

Organizations and Agencies Serving a State, City, or County Group: Set policy for SPAP and MSP eligibility (state organizations only). Develop over-arching strategy for area-wide outreach and enrollment activities. Develop unified messaging. Enlist cooperation of community-based organizations. Train community-level staff and volunteers. Assess and meet needs for information technology. Conduct outreach activities. Triage complex cases.

Local Government/Community Organizations: Modify messages and materials as needed for target audience. Host informational and enrollment events. Maintain enrollment sites. Publicize events and sites. Provide one-to-one assistance. Send complex cases to a higher level.

Source: Phases 1 and 2 case study site visits, focus groups, and expert/stakeholder interviews.

- ***Organization of Flow of Information Top-Down and Bottom-Up.*** To facilitate communication of important information, provide problem resolution, and offer technical assistance, information must flow both downward from national, state, and regional organizations and upward from CBOs. Keeping numerous organizations abreast of policy changes, clarifications, and strategic decisions is critical to the smooth implementation of outreach and enrollment activities. Most of the sites we visited established pathways for communicating important information down to the community level (for instance, when state SHIP offices receive news from SSA and CMS regional offices, they pass it along to local SHIP offices, other important participants, and CBOs). And most study sites also established chains of communication so CBOs could send questions up to broad-based organizations for technical assistance.
- ***Development of Outreach and Application-Assistance Strategies.*** Developing outreach, enrollment, and communications strategies is often the responsibility of

organizations operating at the state, city, or multi-county level. Such organizations usually draw on the expertise of larger CBOs, particularly SHIPs and AAAs, and sometimes on the expertise of CMS regional offices and SSA. Organizations operating at the state, city, or county level have the best vantage point for planning strategy, as they have a sweeping view of area resources yet are close enough to their clients or constituency to identify the most important potential barriers to enrollment.

- ***Development of High-Quality Lists of Potential LIS-Eligible Individuals.*** Identifying who might be eligible for LIS but not for automatic enrollment in the program was a time-consuming and costly undertaking. CMS attempted to provide relevant lists to its partners, but our respondents generally said the lists were not sufficiently targeted to be very helpful because they did not indicate who, among those who were LIS-eligible, were still not enrolled.
- ***Provision of Varying Levels of Program Training.*** After the first Part D enrollment period, many local respondents said they wanted to make sure they did not inadvertently drive off potential LIS-eligible people by telling them, “Sorry, we can’t help you select a drug plan or apply for LIS.” Therefore, some lead organizations, such as AAAs and SHIPs or heads of Medicare-focused coalitions, adopted a “no wrong door” approach that helped beneficiaries obtain Part D and LIS information and assistance from any agency or organization in the area serving Medicare beneficiaries’ health care or social service needs. For instance, most lead organizations in the case study sites devoted significant resources to training as many local information intermediaries in CBOs and local health care providers as funds allowed on the basis of Part D and LIS. Smaller CBOs and intermediaries that lacked the resources to maintain in-house expertise referred beneficiaries to SHIPs, AAAs, local SSA offices, or other organizations with appropriate expertise.
- ***Provision of Appropriate Technological Infrastructure.*** The online LIS application (developed by SSA), Medicare Prescription Drug Plan Finder (developed by CMS), and BenefitsCheckUp (developed by NCOA) were essential components of the CBO assistance infrastructure. Many low-income beneficiaries cannot access or use the online tools on their own, but organizations assisting beneficiaries used them daily. A technological infrastructure, including computers, Internet access, printers and wireless laptops, was usually funded from local or national grants. Respondents noted that technology investments were not merely one-time expenditures but required regular funding to update and maintain.
- ***Development of Simplified, Targeted, Culturally Appropriate Materials and Messages.*** Both CBOs and such broader-based organizations as CMS, SSA, and State SHIP and AAA offices have roles in ensuring that outreach materials, media announcements, applications, and software all present information simply and appropriately; details about Part D and LIS can be addressed through counseling or small group presentations. Responsibility for simplifying beneficiary outreach materials might best rest with national or regional organizations with the resources to devote to materials development and consumer testing. CBOs could then tailor materials and outreach messages to the local community or to particular audiences, such as those who live in relatively isolated rural areas, or who fall within a particular eligibility category (for example, whether they are deemed eligible for LIS or must

apply for it). In addition to developing and simplifying materials, national or regional organizations might prepare materials for particular beneficiary populations in non-English-language translation.

3. Form Comprehensive, Inclusive, and Cohesive Partnerships to Connect CBOs to Supporting Organizations

The discussions above make it clear that partnerships in many forms and across many types of organizations are essential for increasing Part D and LIS enrollment and promoting informed Part D plan choice among low-income beneficiaries. National, state, and county governments must forge partnerships with other public and private organizations, particularly at the community level, to achieve enrollment goals. In turn, CBOs must partner with broad-based organizations to access the infrastructure necessary to effectively implement best practices. Many CBOs also networked with other CBOs to share information, resources, and referrals. Important types of newly formed or forming partnerships that we heard about include:

- ***Partnerships Between Service Providers and Policy Advocates.*** Regular interaction of direct service organizations with policy advocacy organizations can be beneficial to both. As one respondent emphasized, “One informs the other—you don’t know which policies you want to change unless you have experience on the street about what’s going on. ... In the other direction, when a new policy comes out, our education partners can get the word out very quickly.”
- ***Partnerships Between Aging and Disability Networks.*** Partnerships with community providers of health and social services for younger disabled beneficiaries are essential for reaching this population who many respondents still believe are underserved. Historic divisions between the aging and the disability service systems, mainly attributable to different funding streams and oversight agencies, can be overcome through formal and informal coalition building. Moreover, such divisions are likely to diminish in the future as many SHIPs and AAAs now receive funding through Aging and Disability Resource Centers, which are jointly funded by the AoA and CMS and are designed to serve as integrated points of entry into the long-term care system. Many other organizations we talked with were also forming or planning to form new partnerships with agencies that serve disabled persons, such as Centers for Independent Living, local chapters of the Alzheimer’s Association, and HIV/AIDS advocacy organizations.
- ***Partnerships with Elected Officials.*** Local, state, and national elected officials can all contribute to enhancing the effectiveness of a community organization by helping to promote or legitimize the organization’s Part D efforts. In several instances, politicians provided leadership in coalition development, facilitated policy change, or helped shepherd funding requests through the legislative process.

D. WHAT CHANGES IN OUTREACH AND ENROLLMENT ACTIVITIES OCCURRED FROM THE FIRST PART D BENEFIT YEAR TO THE SECOND?

Many organizations geared up to help beneficiaries of all types in the first year of the programs. The national, state, and local organizations that participated in our study undertook a variety of outreach, education, and application assistance activities ranging from professionally produced advertisements and public service announcements; sign-up events in church basements; mass mailings; presentations to groups; telephone hotlines; and booths at health fairs, community clinics, and pharmacies.

Representatives of many organizations interviewed for this report said they made a point of targeting specific segments of the low-income beneficiary population in their Part D and LIS activities. Others, however, while acknowledging the importance of serving beneficiary subgroups, said they lacked the time and resources needed to do so to the desired degree.

Our second-year focus groups with intermediaries and expert/stakeholder interviews and our case study investigated whether strategies or activities for assisting beneficiaries changed after the first Part D enrollment period and, if so, why. We learned that in the program's second year, most organizations continued to use many of the first-year strategies—though on a smaller scale. In addition, they kept intact the general Medicare or Part D-focused coalitions and work groups they had established. However, we did hear reports of some significant changes.

1. Changes in Outreach and Enrollment Activities

a. Some Increased Focus on Low-Income Populations

About half of informal intermediary and health provider focus group participants, stakeholder respondents, and case study interviewees began to focus specifically on LIS in the program's second year. Increasingly, they concentrated on outreach to beneficiaries who did not sign up for LIS in the previous year, new Medicare enrollees, and those who lost their deemed status and had to apply for LIS. However, many others said demand for assistance from current Part D enrollees continued to be so great they spent less time reaching out to potential LIS-eligible individuals in the second year than would have been hoped.

b. Increased Focus on Referrals

After the first Part D enrollment period, organizations still involved in beneficiary assistance wanted to ensure that other agencies or organizations serving the health care or social service needs of Medicare beneficiaries did not inadvertently drive off potential LIS-eligible individuals by an inability to help them. Therefore, to the extent that funds permitted, many organizations concentrated even more heavily in the second year on training CBOs and other professionals, such as social workers and home health care providers, on (1) how to help organizations recognize beneficiaries who might be eligible for LIS or wanted additional Part D assistance, and (2) how to make referrals to someone who can provide the needed information and assistance.

c. **Emphasis on Comprehensive Benefits, Not Just Part D**

To address beneficiary waning attention to Part D and LIS messages in the second year of the program, organizations modified Part D- and LIS-focused presentations to include discussions of broader Medicare program elements, a range of senior benefits, retirement planning, or new Medicare-covered prevention benefits. Many organizations also changed their strategy in the second year from focusing exclusively on Part D and LIS to offering low-income benefit check-ups to low-income individuals in order to maximize resources and improve beneficiary well being. They ran the BenefitsCheckUp program developed by NCOA, which screens for LIS eligibility while checking eligibility for other public benefits such as the Medicare Savings Programs, food stamps, or transportation vouchers.

d. **Greater Use of Online Application Tools**

Informal intermediaries said they made greater use of technology in the second versus first year. In particular, after noticing that SSA processes online applications more quickly (by several weeks) than paper applications, the intermediaries switched from helping beneficiaries file paper LIS applications to helping them file online applications. In addition, several informal intermediaries commented that the CMS Plan Finder tool seemed more user-friendly in the second year than when first introduced.

e. **Attention to Developing Steady-State Practices**

Many organizations realized they lacked the resources needed to maintain the intense level of activities characteristic of the first and second years; many also sensed they had already reached the majority of beneficiaries in some way. Therefore, they began to focus on developing steady-state practices that could be effective in coming years. These practices focused on incorporating Part D and LIS assistance into organizations' *routine* activities while targeting beneficiary subgroups they thought had still not been reached.

Incorporating Part D/LIS Application Assistance into Routine Activities and Curtailing Other Large-Scale Activities. Second-year focus group participants representing CBOs seemed fairly evenly split between those whose organizations had greatly curtailed Part D-related activities during the second year and those whose organizations had made Part D and LIS assistance routine organizational activities. According to these informal intermediaries, providing one-on-one application and enrollment assistance has, for the most part, become a low-volume, routine activity for CBOs that still offer it. In addition, many outreach organizations now work with other social service agencies to screen for LIS eligibility at the same time they screen for their own services. The activities most likely to be curtailed in the second year of Part D/LIS were town hall meetings, large group presentations, large-scale telephone banks, and mass-enrollment clinics. Some focus group participants said they planned to revive such activities for annual open-enrollment periods, but did not intend to offer them year-round.

Focus on Specific Populations. For the most part, organizations still used lists of qualified leads, but some felt their usefulness was waning. During our site visits, most organizations reported that not-yet-reached beneficiaries would require a more targeted approach, even if the organizations were not sure what form the targeting should take or who the beneficiaries might

be. While respondents speculated that these beneficiaries have little contact with health or social service systems—and include homebound individuals, non-English-speakers, rural beneficiaries, and mentally ill individuals—they had little hard evidence that this is true. The case study organizations were searching for innovative yet cost-effective ways to contact groups not reached by earlier efforts. Several organizations used new strategies to try to make contact with the hardest-to-reach beneficiaries, including shifting outreach from the beneficiaries themselves to beneficiary caregivers and focusing on subgroups for whom special content was still needed. Such content included explaining unfamiliar U.S. health care insurance concepts to people with English as their second language, helping dual eligibles understand their rights to switch Part D plans, and assisting beneficiaries who needed unusual drugs.

Focus on New Outreach Partners. In the second year of Part D and LIS, several organizations turned their attention to partner organizations that might be well positioned to assist pockets of hard-to-reach beneficiaries. In one case, county extension agents from the U.S. Department of Agriculture or the National Grange attempted to reach rural beneficiaries. Veterans' organizations have also become outreach partners in many areas. One new practice attempts to reach out to clients of free medical clinics on the belief that although these patients receive prescription drugs at low or no cost they might appreciate the more reliable SPAP and Part D programs.

Focus on Localized, Targeted Outreach Activities. Broader-based activities—mass media, enrollment clinics, national toll-free lines—that worked in the first years of the Part D and LIS programs are less likely to work for beneficiaries who have not yet applied for LIS. Many organizations believe the remaining LIS-eligible populations will require new or modified strategies that are more resource-intensive, localized, and targeted. Support of such steady-state activities will require increased emphasis on formative research to identify beneficiaries who have not yet been reached and the specific approaches and messages most likely to reach them.

2. Reasons for Changes in Outreach and Enrollment Activities

a. Change in Type of Assistance Needed

One explanation for the changes in activities described above was a corresponding change in the types of assistance beneficiaries needed between the first and second program years. The open enrollment period for Part D's first year saw a flurry of activity that generally focused on all Medicare beneficiaries—not just low-income beneficiaries—and the implementation of any effort that could potentially be useful. Some organizations, such as the Access to Benefit (ABC) coalitions, SSA, SPAPs, and Medicaid agencies, devoted considerable effort to reaching out to low-income beneficiaries and promoting LIS, but most organizations, such as SHIPs, AAAs, medical providers, nursing homes, pharmacists, national advocacy organizations, and CMS, made a conscious effort to provide application and decision support to all beneficiaries. In addition, many CBOs targeted their assistance to Medicare clients of all income ranges because of insufficient resources to focus on low-income beneficiaries only.

The second enrollment period at the end of 2006 was slightly calmer because beneficiaries and organizations had developed a better understanding of Part D. For instance, several intermediaries said that by the second year, CMS regional office staff demonstrated increased knowledge about Part D and LIS. However, organizations had to deal with some new issues,

including the re-assignment of beneficiaries to a new Part D plan when the previous plan terminated or increased its premium beyond that covered by LIS, annual recalculation of LIS cost-sharing, and annual redetermination of LIS eligibility. Demand for assistance, therefore, slowed somewhat from the first year but remained high.

b. Waning Attention to Part D

Second-year activities were also affected by what intermediary respondents often termed the “mission fatigue” brought on by a very busy year of providing Part D and LIS training and assistance. Many respondents also told us that beneficiaries were less attentive to Part D messages and information during the second year of the program after hearing so much about it during the first year. Intermediary respondents said that in the second year of Part D, beneficiaries were more likely to attend a presentation or pay attention to materials that addressed their holistic needs, combining Part D information with information on such other topics as retirement planning or changes in social security benefits.

Second year activities were also impacted by the perception—voiced by several CBO staff members in our Phase 2 focus groups and in the case study sites—that federal agencies and other organizations working at higher levels were promoting Part D and LIS less aggressively in the second year and were less committed to keeping CBOs abreast of procedural changes. For instance, intermediaries commented that CMS regional offices were “coming to the community” and providing follow-up information about the state of Part D and LIS less often than in the past. These CBOs believed that without such support their assistance to beneficiaries was less effective than in the first year.

c. Declining Funding

Decreased CBO funding also impacted outreach and education activities in the second year of Part D. One national beneficiary organization with local affiliates said, “The federal government cannot expect local organizations to be able to continue Medicare outreach and enrollment activities without funding. Local organizations do not have the resources.” Several stakeholder organizations also regarded the future of ongoing funding from CMS for outreach and enrollment as uncertain, and this led to a lack of commitment to future efforts by some.

E. WHAT FACTORS AFFECTED THE EASE OF REPLICATING, DISSEMINATING, SUSTAINING, AND EXPANDING BEST PRACTICES?

1. Replicating Best Practices

Throughout our two years of research, we identified a core set of best practices consistently championed by national, state, and local organizations, information intermediaries, health care providers, and beneficiaries themselves. Our case study confirmed that the core set of best practices *can* be replicated in any community in the United States. However, it also clearly underscored that the details on *how* such practices are to be implemented are highly dependent on community characteristics and other contextual factors (Table 1). The practices worked because they were appropriate for the intended audience, the geographic environment, the social

service systems, and the relevant enabling infrastructure. For example, practices that worked in urban areas of a state failed in rural parts of the same state. Chapter VI of the main report provides examples of how these factors play out in real-world situations.

TABLE 1
CONTEXTUAL FACTORS RELEVANT TO REPLICATION

Target Population	Geographic Environment	Social Services System
Attitudes toward government	Size of geographic area	Organization of major state, county, and city government agencies
Knowledge of health care system	Urban, suburban, rural area	Organization of the aging services network
Size of target population	Ease of travel	Experience with collaboration
Demographic characteristics	Types of community venues popular with low-income seniors or people with disabilities	Funding sources

Source: Case study site visits conducted in August 2007.

2. Disseminating Best Practices

Coalitions have been the most important avenue for disseminating Part D, LIS, and best practices information. They can be especially conducive to effective intra- and inter-organizational communications and rapid dissemination of what seems to be working and not working. Coalitions—as opposed to the more general term “partnerships”—were groups of organizations committed, at least short-term, to working together toward a single goal through activities that included developing common outreach strategies and messages, communicating policy changes on a regular basis, and sharing best practices. Coalitions of like-minded organizations were formed or strengthened at the national level (for example, the U.S. Administration on Aging created the National Field Strategy Group, a coalition of about 30 national organizations that have local affiliates; CMS partnered with the ABC chaired by NCOA); at the regional and state levels (for example, CMS regional offices encouraged Medicaid offices to form coalitions with community agencies that could reach LIS-eligible individuals; the ABC coalition in Maine conducted much of its work through its historical involvement in the Maine Medicare Workgroup); and at the local level (for example, the several ABC coalitions made up of CBOs).

3. Sustaining and Expanding Best Practices

Consensus among the focus group and case study respondents held that funding reductions and ebbing energy levels were likely to make the level of effort expended over the past two years of Part D *unsustainable* in the future.

Local organizations were also uncertain about what role they should play in assisting beneficiaries with Part D plan choice given the costliness of the process and the alternative of

auto- or facilitated enrollment for LIS beneficiaries. Several CBO respondents also expressed frustration that the flow of funds to SHIPs often stalled at the state level, and they also reported that the number of professional SHIP counselors was insufficient.

To compound the reduced-funding issues, some strategies that worked well during high-volume periods of Part D and LIS enrollment, such as large call centers and mass-enrollment clinics, may not be as effective or cost-effective during lower-volume, steady-state periods. However, existing telephone helplines, such as those operated by SHIPs and AAAs, could easily make LIS part of their customer service routine.

I. INTRODUCTION

A. PURPOSE OF STUDY

Beginning in January 2006, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) significantly expanded the Medicare program by adding optional benefits for outpatient prescription drugs (Medicare Part D). The MMA also established a low-income subsidy program (LIS) to help low-income beneficiaries—an estimated 12.5 million to 14.2 million of them—pay for Part D out-of-pocket expenses.⁸ The Centers for Medicare & Medicaid Services (CMS) is directing considerable effort at encouraging participation in Part D and LIS for individuals with limited income and resources who are often those most in need of medications they cannot afford. However, experience with low rates of enrollment in a variety of public benefit programs that aid low-income populations suggested there were likely to be significant challenges to Part D and LIS enrollment. In anticipation of such challenges, Congress included provisions in the MMA designed to lower various barriers to enrollment.⁹ Congress also required the secretary of the U.S. Department of Health and Human Services (DHHS) to report to Congress about “best practices in the successful enrollment of low-income beneficiaries” into the new programs.

CMS contracted with Mathematica Policy Research, Inc. (MPR), to conduct a three-year study of best practices to help the agency develop its report to Congress. This report summarizes key findings from our study, designed to investigate the following research areas:

1. The foremost research goal was to identify which of the many activities conducted by national, regional, state, and local organizations during the first and second years of the Part D and LIS programs appeared to be most effective for enrolling low-income beneficiaries into these new programs—that is, what were “best practices.”
2. A secondary goal was identifying the main challenges that low-income beneficiaries faced in applying to LIS and selecting a Part D prescription drug plan. This research

⁸ Estimate of 12.5 million in 2008 potentially eligible for LIS obtained from *CMS Press Release*, January 31, 2008, CMS Office of the Actuary’s eligible estimate based on updated Survey of Income and Program Participation (SIPP) data; LIS estimate of 14.2 million in 2006 potentially eligible obtained from *A Detailed Description of CBO’s Cost Estimate for the Medicare Prescription Drug Benefit*, July 2004, by the Congressional Budget Office.

⁹ Examples include automatic LIS enrollment for full dual eligibles, and SSI and MSP recipients, allowing prescription drug plan auto-assignment for dual eligibles and facilitated enrollment for other LIS applicants. Additionally, the MMA requires states to play a role in LIS applications in order to take advantage of the community referral systems that lead low-income people to state Medicaid agencies to seek assistance to pay for medical costs. Thus, MMA requires states to take and process applications for the LIS program, or to accept and forward LIS applications to SSA. The law also requires states to screen LIS applicants for eligibility for the state’s MSP and enroll them if they qualify. In addition, MMA requires SSA to make available to states, through CMS, information about those individuals who apply for LIS directly to SSA, to assist states in identifying beneficiaries who may qualify for MSP.

area helped us focus attention on practices that effectively addressed those challenges.

3. Also of secondary importance—but fundamental to identifying best practices—was a comprehensive survey of national, regional, state, and local organizational efforts in the first and second program years to raise awareness and understanding of the new programs and to assist low-income beneficiaries with LIS application and drug plan selection.
4. Identifying significant changes in outreach, education, application assistance, and decision support practices from the first Part D benefit year to the second—and the reasons for these changes—sharpened focus on which practices suitable for the first program year of very high demand for assistance would continue to be best practices in the second year as requests for help leveled off and new program issues arose.
5. Finally, we examined the ease with which “best practices” identified during the study might be replicated, disseminated, expanded, or sustained in coming years.

Two years of intense experience providing outreach, education, and assistance to low-income Medicare beneficiaries for the Part D and LIS programs gave study participants a solid sense of what worked well. We were able to identify which of the practices seemed most effective across all situations and populations by asking participants to think of “best practices” in terms of activities or processes that seemed to be most appropriate and effective in identifying, reaching, educating and enrolling a given population in a particular setting.

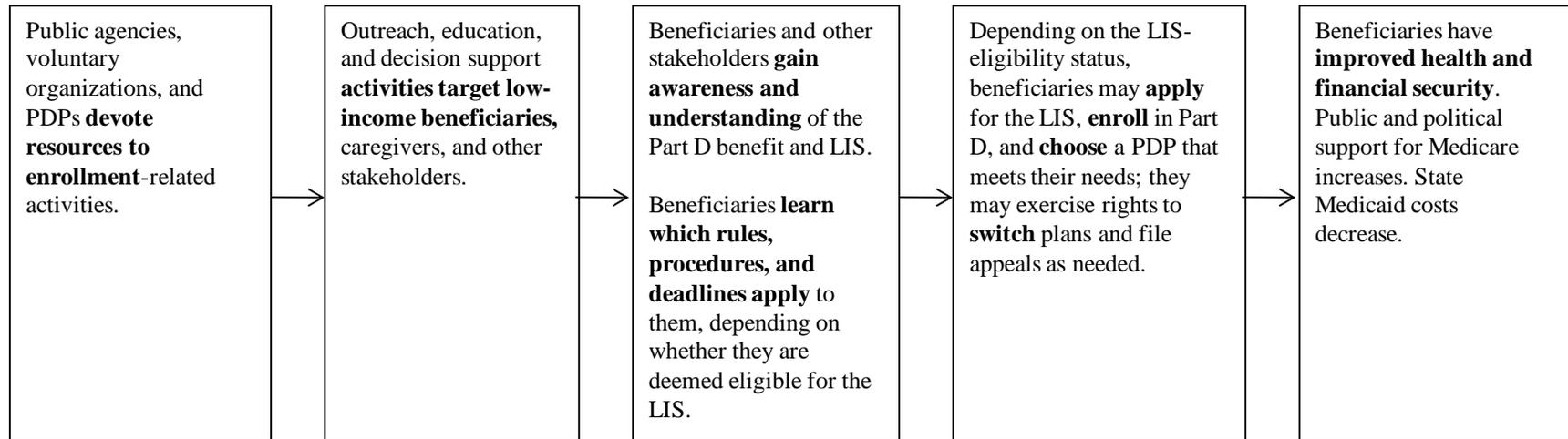
Although respondents from all of our data collection activities candidly shared their opinions about activities that seemed to work well—or not very well—during the first and second years of the Part D and LIS programs, none could substantiate his or her observations with firm evidence of success or failure. Under a subcontract with the National Council on Aging (NCOA), we attempted to collect comparative cost-effectiveness quantitative data on LIS outreach and assistance activities from our case study sites. However, we were ultimately unable to make robust cost-effectiveness comparisons among activities or across sites due to the sizeable challenges involved in collecting retrospective data and attempting to measure effectiveness and explore costs when there are substantial differences in coalition structures, formal partnerships, and supporting infrastructure. Therefore, the best practices described in this report reflect respondents’ observations about practices that seem to be succeeding in the field, as corroborated through our several qualitative data collection activities.

B. BACKGROUND

Beginning January 1, 2006, many low-income beneficiaries became eligible for major financial assistance under the Part D LIS program, but obtaining that assistance required them to travel some unfamiliar paths. Like all Medicare beneficiaries, elderly and disabled individuals with limited incomes and assets also had to choose and enroll in a Part D plan, a process unfamiliar to most. Figure I.1 provides a conceptual model in which a sequence of components leads to the enrollment of eligible Medicare beneficiaries into the Part D and LIS programs and, it is hoped, improved health and financial well being. Past experience with enrollment in a variety of programs designed to aid low-income populations suggested there would be significant

FIGURE I.1

CONCEPTUAL MODEL OF ENROLLMENT IN THE MEDICARE PART D AND LIS PROGRAMS



3

LIS = low-income subsidy; PDP = prescription drug plan.

barriers to enrolling them into LIS and Part D. Estimates indicate, for example, that in the past only about one-half to two-thirds of individuals eligible for the Medicare Savings Programs (MSP) enrolled (GAO 1999, Rosenbach and Lamphere 1999, and Families USA 1998). The Medicare discount card program for prescription drugs—the predecessor to Part D—was also under-enrolled (Health Policy Alternatives 2004; National Association of Community Health Centers 2005).

Enrolling in Part D, choosing a Part D plan, and applying to LIS can be an even more complex process than enrolling in MSP or the prescription discount card program because it requires different steps for different types of beneficiaries. Below, we briefly describe the enrollment process.

Multi-faceted Enrollment Process. Congress assigned responsibility for administering Part D and LIS to three government agencies: CMS, the Social Security Administration (SSA), and state Medicaid agencies. CMS has overall responsibility for implementing the prescription drug benefit. In addition, CMS and State Medicaid agencies had primary responsibility for transitioning dual-eligible beneficiaries from Medicaid into Medicare Part D prescription drug plans in the first year of the program. SSA has primary responsibility for processing LIS applications and determining eligibility, but Congress also required State Medicaid agencies to accept and process LIS applications if requested to do so. Medicare beneficiaries who receive full or partial Medicaid benefits (MSP enrollees) or Supplemental Security Income (SSI) are “deemed” eligible for LIS; in other words, they do not have to apply for program benefits. Low-income beneficiaries who do not fall into either of these categories but have qualifying income and assets for LIS (non-deemed) must apply to SSA or their state Medicaid agency to enroll. (Table I.1 lists the criteria used to classify LIS-eligible beneficiaries as deemed or non-deemed.) Given that CMS, SSA, and state records do not provide sufficient information to determine which individuals may be eligible for LIS, organizations working to increase LIS enrollment must find some method to identify potentially eligible beneficiaries and make them aware of the program.

TABLE I.1

LIS PROGRAM—ELIGIBLE CATEGORIES FOR MEDICARE BENEFICIARIES

Full Benefit Medicaid/Medicare Dual- Eligibles (deemed)
Noninstitutionalized <=100% of the Federal Poverty Level (FPL)
Noninstitutionalized > 100% FPL
Institutionalized (e.g., nursing homes)
Medicare Savings Programs Enrollees (deemed)
Qualified Medicare beneficiaries
Specified low-income Medicare beneficiaries
Qualified individuals
Supplemental Security Income (SSI)-Only Recipients (deemed)
State Pharmaceutical Assistance Program SPAP Enrollees (non-deemed)
<=135% of FPL (lower/higher assets) (non-deemed)
<=150% of FPL (non-deemed)

If full Medicare/Medicaid dual-eligible beneficiaries do not select a Part D plan within a specified period, CMS auto-enrolls them in a plan at random. For other deemed beneficiaries and non-deemed LIS applicants who do not select a plan, CMS facilitates Part D plan enrollment. The plan into which a beneficiary will be auto-enrolled or facilitated enrolled is based on where the person currently gets their Parts A and B benefits, and whether the Part D premium is at or below the low-income premium subsidy amount. To enroll in a Part D plan of their own choice, all low-income beneficiaries must learn about the available plans in their state, recognize which plans charge the same or less than the low-income premium subsidy amount, compare the plans' formularies and out-of-pocket costs, and then submit their choice to CMS. All LIS enrollees may change Part D plans on a monthly basis (this provision is fairly new for non-deemed LIS applicants).

Diverse Beneficiary Characteristics. The sometimes complicated route that low-income individuals must follow to obtain LIS and Part D benefits is just one of the factors that can make enrollment particularly challenging. Another is that this is a very diverse group, which includes non-English speakers; people with low literacy; and individuals with vision, hearing, cognitive impairments; or mental illness. Consistent with past research on low-income populations in the U.S., we found in our study that distrust of government, transportation constraints, and confusion over program rules and terminology are among the most difficult obstacles to overcome. These are compounded by beneficiary inertia (or lack of motivation to change) and indecision as additional barriers. Outreach and education efforts also must address the differences in approach required for beneficiaries living in diverse geographic locations (rural counties versus inner cities for example), living situations (beneficiaries living in their own home versus a long-term care nursing facility), of different ages (under-age-65 disabled beneficiaries versus frail elderly over age 85, for instance), and beneficiaries of different races, ethnicities, and cultural backgrounds.

C. METHODS

We gathered qualitative data from four sources to address the study's areas of inquiry:¹⁰

1. Telephone interviews from May through July 2006 with 30 stakeholders and independent experts responsible for or familiar with the overall design and implementation of Part D/LIS outreach, education, and enrollment strategies in the nation, states, and local communities
2. An additional set of telephone interviews similar to those in 1., conducted in March and April 2007 with 20 stakeholders and independent experts
3. A mail survey of each state Medicaid office, State Health Insurance Assistance Program (SHIP), and State Pharmaceutical Assistance Program (SPAP) in the 50 states and the District of Columbia about their Part D and LIS activities in fall/winter 2006

¹⁰ Appendix A provides brief descriptions of the data sources. Lists of respondents and research tools used in the study are available from CMS upon request.

4. A case study of promising practices in six sites across the U.S. in summer 2007¹¹
5. Two sets of focus groups (conducted in fall 2006 and fall 2007) with low-income deemed, formerly deemed, non-deemed Medicare beneficiaries, and non-deemed LIS applicants,¹² “information intermediaries”¹³ who assisted beneficiaries with LIS applications and Part D plan choice, and health care providers (pharmacists, physicians, nursing home administrators, and family caregivers of nursing home residents).

D. ROADMAP TO THE REPORT

To establish the setting for understanding why respondents identified some activities as best practices, Chapter II of the report first describes the “early implementation” (Phase 1) experiences of low-income beneficiaries, particularly the many challenges they faced in both applying to LIS, enrolling in Part D, and understanding their prescription drug plan choices and benefits. Chapter III describes the numerous activities of national, state, regional, and local organizations that provided Part D and LIS outreach, education, and application and enrollment assistance during the first and second Part D open enrollment period (from late 2005 through mid-2006). This early implementation research set the stage for identifying potential best practices for effective program enrollment in Phase 2 of the study.

In Phase 2—summer 2006 through summer 2007—we explored whether potential best practices identified during the first year of Part D and LIS were still considered the best ways to enroll low-income beneficiaries after one year of “experienced implementation” efforts. Chapter IV examines changes in organizational outreach and enrollment strategies and activities between the first and second years of the programs and the reasons for such changes. Chapter V synthesizes what we learned during the two phases of our study to present findings on best practices, and Chapter VI describes factors that appear to make these practices most effective.

¹¹ The six sites were Maine, metropolitan Atlanta, greater Cleveland, the Chicago suburbs, southern New Mexico, and Idaho.

¹² Deemed status refers to beneficiaries who automatically qualify for LIS subsidies because they are dually eligible for Medicare and Medicaid benefits, participate in the Medicare Savings Programs, or receive Supplemental Security Income. Non-deemed individuals are low-income beneficiaries who must actively apply for LIS benefits through the Social Security Administration (SSA) or their state Medicaid office; non-deemed LIS applicants are beneficiaries who applied for and were determined qualified to receive LIS benefits.

¹³ In general, an information intermediary is someone who can answer health care consumers’ questions, address concerns, and help them apply information on health care programs and benefits to their personal situations. “Informal intermediaries” in our study include the types of CBOs that many state and local government agencies partnered with to promote Part D and LIS enrollment: adult day centers, housing complexes for seniors or low-income residents, senior centers or senior services organizations, legal aid organizations for low-income persons, Centers for Independent Living (CIL) that provide services to people with physical or mental disabilities, and organizations that serve clients who belong to specific ethnic groups or have certain illnesses or chronic conditions. Health care providers (such as “safety-net” hospitals, FQHCs, primary care clinics, and retail pharmacies) also function as informal intermediaries for sharing Medicare information with beneficiaries and family caregivers. “Formal intermediaries” in our study refer to the type of CBOs that had clear responsibility and specific funding to help educate and enroll beneficiaries in Part D and LIS, and that also serve local communities. Formal intermediaries consist of locally based Medicaid, SSA, SHIP, and AAA offices.

Chapter VI also discusses factors that support replication of best practices across different geographic areas or for beneficiaries with various characteristics, and discusses the likelihood that organizations still involved in helping Medicare beneficiaries enroll in Part D and LIS in Year 2 will maintain or expand their activities in the future.

II. WHAT WERE THE KEY CHALLENGES TO BENEFICIARY ENROLLMENT?

As background for identifying best practices, we first explored the many challenges that low-income beneficiaries faced in applying to LIS, enrolling in Part D, and comprehending their prescription drug plan choices and benefits. We conducted two rounds of focus groups and interviews with beneficiaries and organizations that serve low-income beneficiaries on a daily basis (information intermediaries) to understand the difficulties confronting them. Both types of respondents cited several challenges to LIS and Part D application or enrollment, as well as beneficiary confusion about the programs.

With only a few exceptions, most beneficiaries described at least one impediment to engaging in the LIS application process (non-deemed beneficiaries) or understanding the role played by CMS in enrolling beneficiaries in a Part D plan (deemed and non-deemed beneficiaries). The impediments most often mentioned by focus group beneficiaries included vision problems, language barriers, limited literacy, and not knowing trusted people who might help them understand Part D.

Although deemed and non-deemed beneficiaries follow different paths to Part D and LIS enrollment, we found that the two groups had similar experiences in many ways. Deemed beneficiaries—automatically eligible for LIS benefits and auto- or facilitated-enrolled in a Part D plan—were, nevertheless, confused by many aspects of Part D or simply suffered from “information overload.” Beneficiaries were uncertain about the difference between Part D and LIS and the difference between Medicare Advantage Prescription Drug Plans (MA-PDs) and stand-alone drug plans. Non-deemed beneficiaries cited confusion over the same issues; they did not know the difference between Part D drug plan benefits, the prescription drug benefits offered under their state’s SPAP, and drug benefits offered through an MA-PD. Both deemed and non-deemed groups also noted considerable confusion about their new benefits—how Part D differs from their previous prescription coverage and how it fits with Medicare Part A and B coverage. Many beneficiaries also demonstrated only a limited understanding of how they came to be enrolled in the programs. For example, among non-deemed beneficiaries who had applied and were approved for LIS (according to CMS data), only about half seemed to have heard of the subsidy (promoted to them as “Extra Help”), and even fewer believed they were eligible for it. Although the Phase I focus group and telephone discussions revealed that most deemed beneficiaries in four case-study sites knew of their right to switch plans, Phase 2 results indicated that only about half of beneficiaries knew that they could switch to another prescription plan.

Given all of these challenges, it is clear that most low-income beneficiaries needed, and likely will continue to need, assistance from others to understand the Part D and LIS enrollment processes and program benefits. Also, low-income beneficiaries eligible for LIS but not automatically enrolled must be made aware of the extra financial help available to pay for Part D out-of-pocket costs and how to apply to the program.

III. WHAT TYPES OF OUTREACH, EDUCATION, AND ENROLLMENT ACTIVITIES TOOK PLACE DURING THE FIRST TWO YEARS OF PART D AND LIS?

Many organizations geared up to help all types of beneficiaries deal with obstacles to Part D and LIS enrollment; some even mobilized before the programs' January 2006 launch. To understand the strategies and practices pursued by these organizations—particularly those related to helping low-income beneficiary groups—we consulted our state survey of Medicaid, SHIPs, and SPAPs; conducted two rounds of interviews with experts and stakeholders involved in Part D and LIS outreach, education, and enrollment; and reviewed documentation of activities in reports and on the Internet.

In addition to their program administration responsibilities, CMS, SSA, and state Medicaid agencies were charged with identifying beneficiaries and educating them about Part D and/or LIS extra help. Moreover, some national, state, and local organizations took it upon themselves—some funded by federal and state agencies, others funded by private foundations or national advocacy organizations, and others without receiving additional funding—to provide outreach, education, application assistance, and prescription drug plan decision support to low-income beneficiaries. The ultimate objective of these activities was to motivate low-income individuals to apply for the LIS, enroll in Part D, and choose a Part D prescription drug plan wisely. This chapter of the report presents an overview of the numerous activities implemented during the first two years after introduction of Medicare Part D.

A. OVERVIEW OF LIS AND PART D ACTIVITIES

The national, state, and local organizations that participated in our study described a variety of outreach, education, and application-assistance activities they undertook, ranging from professionally produced advertisements on television networks to sign-up events in churches. The most common activities for awareness and engagement were mass mailings, public service announcements, advertisements, and presentations to groups. Enrollment assistance and decision support were provided mostly through sign-up events, telephone hotlines, and booths at health fairs, community clinics, and pharmacies. Table III.1 provides examples of the types of activities conducted during the first two years of Part D.

TABLE III.1

EXAMPLES OF PART D/LIS ACTIVITIES BY ORGANIZATION TYPE

Organization	Examples of Activities
Centers for Medicare & Medicaid Services (CMS)	<ul style="list-style-type: none"> • Mailed beneficiary notices regarding auto- and facilitated enrollment and LIS deeming, plan reassignment, and redeeming • Assigned LIS enrollees to Part D plans, as needed • Developed outreach tool kits for states and localities • Provided personal assistance to beneficiaries through Medicare toll-free telephone helpline • Provided additional funding to SHIPs to assist with Part D counseling and assistance • With AoA, provided additional funding to n4a and NASUA to assist with Part D education and outreach • Provided funding to federally recognized SPAPs for Part D coordination and outreach • Formed partnerships with public- and private-sector partners at the national, state, and local levels, including the U.S. Administration on Aging (AoA) and the National Council on Aging (NCOA) • Developed online Medicare Prescription Drug Plan Finder • Created a website with Part D information for pharmacists
Social Security Administration (SSA)	<ul style="list-style-type: none"> • Determined eligibility for LIS applicants • Developed online LIS application • Mailed LIS applications to nearly 19 million potential LIS-eligibles and conducted followup • Used SSA’s standard agency mailings to disseminate information • Organized or participated in tens of thousands of community informational events through local SSA offices • Coordinated targeted advertising efforts with national organizations and target outreach events with state organizations • Targeted mailings to beneficiaries with representative payees, beneficiaries who speak Spanish, Asian American and African American households, and beneficiaries age 79 and older who live in ZIP codes with a high percentage of low-income households • Implemented an outreach strategy aimed at relatives and caregivers of Medicare beneficiaries • Connected LIS outreach activities with SSA’s MSP outreach • Briefed states on LIS • Held targeted events at locations frequented by seniors and persons with disabilities • Worked in partnership with pharmacies and medical providers

TABLE III.1 (continued)

Organization	Examples of Activities
State Agencies (Medicaid, SPAPs)	<ul style="list-style-type: none"> • Determined eligibility for LIS applicants • Modified MSP and SPAP application forms or eligibility criteria to facilitate automatic LIS eligibility • Participated in CMS’s State Pharmacy Assistance Program Working Group • Set up SPAPs to provide Part D wrap-around coverage • Established “intelligent auto assignment” and co-branding approaches to Part D plan choice • Operated telephone hotlines • Conducted media campaigns • Provided one-on-one assistance • Targeted Part D/LIS outreach to people other than Medicare beneficiaries, such as pharmacists and family members
Formal Intermediaries (SHIPs, Area Agencies on Aging [AAAs])	<ul style="list-style-type: none"> • Developed and led state and local coalitions of CBOs and stakeholders • Developed Part D/LIS outreach and education strategy for communities served by coalitions and CBOs • Provided direct program application and decision support assistance to beneficiaries • Designed and implemented state-wide and local media campaigns • Operated telephone hotlines • Provided training to informal intermediaries and health care providers • Provided training to professionals to facilitate cross-screening and cross-referrals among low-income benefit programs • Held beneficiary presentations • Developed web-based clearinghouse located at http://www.medicareoutreach.org (AAAs)
Advocacy Organizations (national and state-level)	<ul style="list-style-type: none"> • Conducted Part D–specific outreach and education campaigns • Provided funds or volunteers to support state and local organizations • Supported CBO efforts by recruiting volunteers • Planned or helped coordinate national efforts carried out by CBOs’ state or local offices • Conducted national outreach and education campaigns • Developed BenefitsCheckup (NCOA)
Informal Intermediaries (CBOs other than locally-based SHIPs and AAAs)	<ul style="list-style-type: none"> • Provided comprehensive one-on-one assistance • Identified potential LIS-eligible beneficiaries • Provided meeting space for information and enrollment sessions • Leveraged rapport with low-income beneficiaries • Designed and implemented local media campaigns

TABLE III.1 (continued)

Organization	Examples of Activities
Health Care Providers (pharmacists, physicians, nursing home administrators, and health plans)	<ul style="list-style-type: none"> • Provided troubleshooting at prescription counter • Placed information and marketing materials in display racks • Accepted invitations to speak at local venues • Provided in-store Internet access • Facilitate CMS’s “point of sale” system to enroll low-income beneficiaries for which the pharmacist cannot find billing information into a Part D plan that enables them to receive their medications • Printed plan formularies for beneficiaries and informal intermediaries • Directed customers to local service agencies, Medicare website, or Medicare hotline • Hosted in-store sessions to help customers enroll in Part D • Worked to change beneficiaries’ medications to ones covered by beneficiaries’ Part D plan • Provided in-person Part D plan decision support • Targeted outreach and education materials to family caregivers • Developed specific health plan materials for low-income populations

Local organizations generally used existing staff members, temporary staff members, and sometimes volunteers to provide application assistance and decision support. Staffing patterns varied, however, depending on the resources organizations could marshal quickly. Organizations that provided enrollment assistance and decision support often found it difficult to adequately staff these activities, according to respondents across all of our study activities.

Representatives of many organizations interviewed for this report said they made a point of targeting specific segments of the low-income beneficiary population in their Part D and LIS activities. However, specifically in the first year of the program, many other organizations that work with the general Medicare population said they lacked the time and resources needed to do specific targeting. These latter organizations were more apt to deliberately cast a wide net in the first year of Part D to serve as many types of beneficiaries as possible, with some turning to focus more on low-income and hard-to-reach beneficiaries in the second program year. Several organizations that assist beneficiary subgroups with all kinds of issues conducted special Part D and LIS outreach and application assistance activities for them, relying on different messengers to deliver specialized content. Some translated written materials into other languages and developed special content to explain unfamiliar concepts. For example, an organization serving Asian American beneficiaries translated the LIS application into Chinese, Korean, and Vietnamese and developed online plan-finder tools in these languages. The same organization ran a telephone hotline with a multilingual staff to provide one-on-one enrollment assistance to beneficiaries.

B. CMS AND SSA (INCLUDING CENTRAL AND REGIONAL OFFICES)

CMS’s major activities included (1) mailing beneficiary notices regarding auto- and facilitated-enrollment and LIS deeming, plan reassignment, and redeeming; (2) assigning LIS enrollees to Part D plans, as needed; (3) developing outreach tool kits for states and localities; (4) providing personal assistance to beneficiaries through its toll-free telephone helpline; (5)

providing additional funding to SHIPs to assist with Part D counseling and assistance, and (6) providing funding to federally-recognized SPAPs for Part D coordination and outreach.

In April 2005, CMS also greatly increased its budget for MMA-related educational activities and formed partnerships with public- and private-sector partners at the national, state, and local levels, including the AoA and NCOA. These national organizations, in turn, worked with their own local community networks to help low-income beneficiaries understand and enroll in the Part D and LIS programs. A large portion of CMS's increased budget was allocated to its own call center, 1-800-MEDICARE, but additional funds were also used for community-based outreach (MedPAC 2006).

In addition to funding its outreach and enrollment partners, CMS created a special section on its website to assist them with information and downloadable materials. During enrollment for the 2006 benefit year, these materials included a "Help is Here" resource kit with detailed steps for helping—beneficiaries apply for the LIS and choose and enroll in a Part D plan. The agency trained many partners to use its online tool—the Prescription Drug Plan Finder—and created a special website with Part D information for pharmacists. Additionally, even though CMS expended significant effort to assure a seamless transition for dual eligibles from their Medicaid drug benefit to Medicare Part D coverage in the first year of the program, there were still cases in which pharmacists could not find any plan information in the computer processing system. In these cases, CMS contracted with WellPoint, a health benefits company, to establish a "point of sale" system to enroll low-income beneficiaries into a plan that enabled them to receive their medications. This program was designed to make sure that individuals eligible for LIS, but were not yet enrolled in a prescription drug plan, were still able to obtain prescription drugs at the pharmacy when the pharmacist believed they had legitimate evidence of both Medicare and Medicaid eligibility.

SSA's involvement in the overall Part D effort was and still is to help low-income beneficiaries apply for the LIS. Between May and August 2005, SSA mailed LIS applications to nearly 19 million potentially eligible individuals with a letter encouraging them to apply and instructions on how to do so. SSA also hired a contractor to conduct follow-up phone calls and mail follow-up notices to beneficiaries who did not respond to the initial mailing, resulting in telephone contacts with millions of potential enrollees. SSA continues to use its standard agency mailings to inform the public. For example, the cost-of-living adjustment notice sent in November 2006 to more than 50 million Social Security beneficiaries contained information about the Part D and the LIS.

After the initial mailings, SSA organized or participated in tens of thousands of informational events at senior centers, hospitals, pharmacies, clinics, and senior housing units. Since 2005, SSA has been involved in outreach and education to local communities through its local SSA offices, including assisting with presentations at senior citizen centers, pharmacies, public housing, and churches. SSA has also continued to work with SPAPs, SHIPs, AAAs, local housing authorities, community health clinics, prescription drug plans, and others to identify people with limited income and resources who may be eligible for LIS. Also, it has coordinated targeted advertising efforts with national organizations such as AARP, and targeted outreach events with state organizations such as the Elderly Pharmaceutical Insurance Coverage program in New York. In additional efforts to reach specific communities, SSA has undertaken targeted mailings to beneficiaries with representative payees, beneficiaries who speak Spanish, Asian

American and African American households, and individuals age 79 and older who live in ZIP codes with a high percentage of low-income households.

In a special outreach effort launched in 2007, SSA implemented a new strategy aimed at relatives and caregivers of Medicare beneficiaries. Components of the strategy included SSA employees across the country visiting their local community centers, grocery stores, restaurants, and churches during the week immediately preceding Mother's Day to make information about LIS available on or around the Mother's Day weekend. SSA also published related articles in local media outlets, and distributed special pamphlets explaining the LIS program, entitled "This Mother's Day, Show Someone You Love How Much You Care." A second series of targeted events was scheduled for Father's Day.

SSA has also connected LIS outreach activities with its MSP outreach, including information on the LIS program with MSP mailings to beneficiaries and sharing their list of potential MSP eligible individuals with state Medicaid agencies.

As the aforementioned activities demonstrate, during the past two years, CMS and SSA have shared components of the larger infrastructure essential to conduct effective outreach and enrollment, such as marketing support and online tools with several agencies and organizations. Although low-income beneficiaries might not use such tools as the LIS Application (developed by SSA) and the Medicare Prescription Drug Plan Finder (developed by CMS) on their own, organizations helping them said they use these tools daily. According to our 2005-2006 survey of state agencies, most said they had worked with federal and regional CMS offices in conducting outreach and education (79 out of 84 agencies). Nearly as many (76) said they had worked with federal, regional, or local offices of the SSA. Both CMS and SSA provide toll-free helplines, but we found all case-study sites relied on one-on-one assistance at the local level. CMS regional offices provided comprehensive training on the Part D and LIS programs, which other state, city, and county agencies often condensed and tailored to train small CBOs and volunteers. Communications directors in CMS regional offices also sometimes helped local organizations devise strategies for message dissemination, as we heard from one site.

C. STATE AGENCIES (MEDICAID, SPAPS)

MMA requires states to take and process LIS applications, whether they arrive as SSA application forms (which Medicaid must forward to SSA) or requests for state determination of LIS eligibility (which they must process themselves). A recent AARP-sponsored study of eight states examined how SSA and state Medicaid agencies met their responsibilities under MMA to accept and process LIS applications during the first 18 months of the program's implementation. The study's authors found that most state and local Medicaid agencies had taken a laissez-faire attitude toward these responsibilities (Lipson et al. 2007). Only one of the eight study states—Kansas—developed its own LIS application and processed eligibility for the program, although Kansas did not generate much LIS enrollment. Kansas respondents said this was mainly because, unlike the SSA application process, an applicant must visit the Medicaid office to apply, and provide documentation about income and assets (consistent with CMS guidance to states). As a result, someone wanting to apply only for LIS would usually be referred to SSA.

In addition to direct LIS application, individuals who apply to state Medicaid agencies and are found eligible for full Medicaid or MSP benefits are automatically deemed eligible and enrolled into LIS. Several states took advantage of this rule to increase enrollment in LIS. As described in the AARP-sponsored study, one state modified its MSP application form to allow individuals to apply for LIS at the same time so they could qualify for either program without having to submit separate applications. Three study states went even further, waiving the asset test for their MSP programs (achieved by disregarding all assets). Vermont removed its asset test at the time of Medicare Part D implementation; Arizona and Alabama had removed the MSP asset test prior to the start of Part D. In our own study activities, we learned that Maine also eliminated its asset test in February 2006 and, additionally, in April 2007 raised the income eligibility threshold for MSP to be comparable to the more generous LIS limits (and with its state SPAP program), with the intent of making more people eligible for MSP and thus LIS. Vermont's and Maine's MSP changes also made most SPAP clients in the two states eligible for the LIS without having to apply for it. Vermont went even one step further and auto-enrolled its SPAP members into the MSP.

The MMA provided special relief for SPAPs—state-funded programs that provide financial assistance for prescription drugs to low-income and medically needy senior citizens and individuals with disabilities. The law allows SPAPs to “wrap around” the Medicare benefit to fill gaps in coverage. The MMA also provided \$125 million in grants for fiscal years 2005 and 2006 to 21 SPAPs to educate their enrollees about the new benefit and to help assure a smooth transition. Additionally, the MMA required the Secretary of DHHS to establish a State Pharmaceutical Assistance Transition Commission to help ensure that low-income beneficiaries who currently receive drugs through their state will continue to get drug benefits without additional paperwork under Part D. CMS also established a State Pharmacy Assistance Program Working Group with representatives from SPAP states to ensure that SPAP issues are addressed effectively. The Working Group helped develop guidance for SPAP states on educating beneficiaries about their new coverage options and setting up wrap-around coverage.

According to our expert interviews, SPAPs can take two main paths to help people enroll in the LIS: (1) facilitate their LIS application with SSA (New Jersey followed this route, for example), or (2) change MSP eligibility requirements so SPAP enrollees become eligible for MSP and the LIS (Vermont and Maine are examples). Some states also took other steps to encourage SPAP applicants to apply to LIS by requiring proof of LIS application prior to SPAP approval or to maintain their SPAP benefits. Pennsylvania and New York, for example, did not at first mandate that SPAP applicants show proof of application to LIS in order to remain in the SPAP program, but New York has since changed its rules, and now requires people to apply; Pennsylvania was moving in that direction at the time of our study. Since our study, more state SPAPs have adopted this approach. States with SPAPs have the authority to apply for LIS on behalf of the beneficiary (in the case of non-duals), but at the time of our study, only Pennsylvania, Maine and New Jersey sought and obtained this authority. In addition to these states' efforts, several SPAPs integrated LIS asset questions into their SPAP applications. Specifically, none of the SPAPs had asset requirements for their own programs, but they added requests for asset information into their applications in order to gather general information about LIS eligibility (Missouri, Montana, Nevada, Indiana, and Rhode Island, for example, did this). Several SPAPs also included expanded income questions on their SPAP applications in order to target their own outreach to LIS-eligible beneficiaries.

However, according to our interviews with experts, with the exception of New Jersey, Vermont, Maine, Pennsylvania, and New York, SPAPs generally spent less effort to get people into LIS and more effort to get SPAP enrollees into a Part D plan. The experts speculated this might be due to confusion on the part of SPAPs about LIS being a separate application, so they did not focus on it. Additionally, they reasoned that New Jersey has a large staff that does in-house eligibility determination (whereas other states use an outside vendor), so perhaps New Jersey was more familiar with doing eligibility determinations and felt comfortable focusing on the LIS application process.

MPR's 2005-2006 survey results for the first six-months of Part D implementation indicated that many of the responding state Medicaid agencies and SPAPs operated telephone hotlines or devised media campaigns, and most of these served the general Medicare population. Several SPAPs and slightly more than one-half of Medicaid agencies that used direct mail (15 out of 28) said they adapted the material for a low-literacy audience. At least half the Medicaid agencies said they provided one-on-one assistance (8 out of 17) and a larger proportion of those operating telephone hotlines or call-in centers (14 out of 19) said they could accommodate non-English speakers. Only a handful of Medicaid agencies that conducted on-site events (4 out of 23) did so in languages other than English. Among the 11 SPAPs that responded to our survey, six said they adapted activities for non-English speakers.

Also according to our survey, Medicaid agencies and SPAPs indicated they tried to reach out to people other than Medicare beneficiaries about Part D and the LIS, on the belief that such people would help inform potential enrollees about the Part D and LIS programs and answer some of their questions. Many of the Medicaid agencies reported that they targeted pharmacists (28 out of 32), while fewer (14 or 15) targeted senior center directors, family members, or social workers. Among the 11 SPAPs that responded to our survey, many targeted pharmacists and senior center directors, but few targeted family members or social workers. The lack of continued funding for SPAPs, has led to a virtual cessation of such activities, according to our expert and stakeholder interviews.

During our interviews and case study site visits, we also heard that a handful of state SPAP programs were employing "intelligent auto (or random) assignment" and/or "co-branding" strategies for SPAP-eligible beneficiaries. Under intelligent assignment, states generated a list of three at-or-below-benchmark-premium Part D plans most suited to a beneficiary's prescription drug needs and allowed the person to select one of them. If the person waited too long to choose, he or she would be randomly assigned to one of the three plans. Some expert and stakeholder respondents asserted that the intelligent assignment approach improved the matching of Part D plan benefits to beneficiaries' prescription drug needs compared with pure random plan assignment. A couple of states also employed "co-branding," under which an SPAP would indicate that some Part D plans were a state "preferred" plan. Although states could not exclusively enroll individuals into a preferred plan, they could inform beneficiaries that the plan was preferred. We were told that New Jersey's combination of intelligent-assignment and co-branding led to preferred Part D plans in the state having higher enrollments than non-preferred plans.

D. FORMAL INTERMEDIARIES (SHIPS, AAAS)

SHIPs and AAAs have been at the forefront of most of the community-level activities we heard about, developing and leading state and local coalitions of CBOs and stakeholders, developing Part D/LIS outreach and education strategy for their communities, and providing direct program application and decision assistance to beneficiaries. As described in Chapter III of this report, both groups often played a primary role in the best practices identified. From what we were told, SHIPs and AAAs generally attempted to serve a more diverse audience than Medicaid agencies or SPAPs. For example, our 2005-2006 survey of state agencies found that compared to Medicaid agencies, a larger proportion of SHIPs (17 out of 34) conducted events in languages other than English. In addition, roughly two-thirds of SHIPs that provided one-on-one assistance by telephone or in person did so in languages other than English. Also, SHIPs were more likely to partner with private organizations or coalitions (reported by 30 out of 35 SHIPs) than were Medicaid agencies (17 out of 32) and SPAPs (4 out of 11).

SHIP is a national program that offers one-on-one counseling and assistance to people with Medicare and their families through CMS grants directed to states. The state grantees have built the SHIP network nationwide to include more than 1,300 local sponsoring organizations supporting more than 12,000 counselors (mostly volunteers) and staff. CMS made SHIPs a cornerstone in its strategy to provide Part D/LIS outreach and assistance to every community in the U.S. In April 2005, for instance, CMS announced \$31.7 million in new funding for SHIPs, in part due to MMA legislation; recently, CMS announced its plan to distribute \$15 million in additional SHIP funds in 2008 to identify and educate beneficiaries who may be eligible for LIS, and to assist with the application process. These funds can also be used to invest in infrastructure development, such as technology tools and training enhancements.

The fundamental mission of the 655 AAAs and more than 230 Title VI Native American aging programs in the U.S. is to provide services to make it possible for older individuals to remain in their homes. These agencies coordinate and support a wide range of home- and community-based services, including information and referral, home-delivered (Meals-on-Wheels) and congregate meals, transportation, employment services, homemaker assistance, senior centers, adult day care and a long-term care ombudsman program. Along with SHIPs, AAAs have also been heavily involved in providing Part D and LIS outreach, education, and assistance to beneficiaries at the community level, although most received minimal, if any funds to provide this assistance during the first year of the program.

After the first year, however, the AoA and CMS recognized the important role of the national aging services network in organizing national and grass-roots-level outreach and education for the Medicare community. These two agencies provided additional funds to support local AAAs in their Part D/LIS work through the National Association of Area Agencies on Aging (n4a)—the umbrella organization for AAAs—and the National Association of State Units on Aging (NASUA)—a non-profit association representing the nation’s 56 officially designated state and territorial agencies on aging. Most recently, for example, in 2008 the AoA again contracted with n4a to take the lead in coordinating the Community Based Enrollment Campaign in Medicare. This effort will help mobilize the aging services network to assist and educate the maximum number of low-income persons with Medicare apply for LIS and join a Medicare prescription drug plan. Additionally, this year’s project will also support the *My Health, My Medicare* outreach campaign to help beneficiaries understand their full Medicare benefits,

including prevention benefits added to Medicare under the MMA. In the past two years, n4A and NASUA have also assisted AAAs in meeting the demand for Medicare Part D information and assistance by conducting training programs, developing promotional and technical assistance materials, and providing best practice profiles to AAAs. Additionally, n4a and NASUA developed a web-based clearinghouse located at <http://www.medicareoutreach.org> to provide easy access to resources and information on outreach and education activities being utilized within the aging network.

E. INFORMAL INTERMEDIARIES (ADVOCACY ORGANIZATIONS, CBOs)

National Organizations. Our interviews with experts and stakeholders revealed that many different types of national organizations have been involved in outreach, education, and enrollment assistance for low-income beneficiaries. Organizations vary in terms of structure, resources, constituencies, and affiliations. Some organizations are membership-based and/or have state or local offices or affiliates. Larger organizations may have the infrastructure and resources to maintain dedicated marketing staff, plan and implement Part D-specific outreach and education campaigns, and provide financial or non-financial support to local organizations. All of the organizations we spoke with represent different populations; some focus on low-income beneficiaries, some on persons with disabilities, and some on persons of all income levels.

The national organizations serving specific ethnic and/or racial populations noted that there is so much diversity within their constituencies that locally-based strategies and activities are necessary. Similarly, the large majority of the other broad-based organizations we interviewed acknowledged that some activities are more effectively done at the local level. One national organization explained that they do not engage in enrollment assistance themselves, but provide funding or volunteers to support state and local organizations that can more effectively conduct outreach and enrollment activities. In other instances, national organizations supported efforts of community-based organizations (CBOs) by recruiting volunteers, or they planned or helped coordinate national efforts carried out by state or local offices.

Some organizations have national outreach and education campaigns, as described earlier, but others use less formal methods, “going wherever the need is.” Despite these differences, most national organizations emphasized the importance of providing one-on-one assistance and establishing relationships with CBOs to share information, make referrals, and provide a “one-stop shop” at community events. Some of the national organizations rely on grant funding and said they have had to truncate many of their activities, including work with community organizations, in the second year because of limited funding.

Community-Based Organizations. We use the term CBOs in this report to refer to two types of local organizations that serve a client base within a city, a county, or a group of counties. “Informal intermediaries” include the types of CBOs that many state and local government agencies partnered with in their efforts to promote Part D and LIS enrollment: adult day centers, housing complexes for seniors or low-income residents, senior centers or senior services organizations, legal aid organizations for low-income persons, Centers for Independent Living (CIL) that provide services to people with physical or mental disabilities, and organizations that serve clients who belong to specific ethnic groups or have certain illnesses or

chronic conditions. “Formal intermediaries” refer to the type of CBOs that had a clear responsibility and specific funding to help educate and enroll beneficiaries in Part D and LIS, and that also serve local communities, encompassing local Medicaid, SSA, SHIP, and AAA offices. Most often, formal intermediaries that in turn forged relationships with informal intermediaries said this practice was key to reaching and engaging low-income beneficiaries of all types, especially those who belong to racial/ethnic minorities or who live in rural areas.

Our multiple research activities not only confirmed the assertion that CBOs often have advantages over organizations operating at a broader level (discussed in Chapter III), they also added nuance to our understanding of the roles that CBOs, whether acting as formal or informal intermediaries, can play effectively. A pertinent reality is that these organizations vary greatly in size, level of resources, and technical sophistication and range from legal aid organizations, whose primary mission is not Medicare-related, to large nonprofit organizations with established presences in the aging-services networks of their communities. Because CBOs vary so much in mission and resources, the organizations we interviewed are deliberate in what they rely on individual CBOs to do:

- Some CBOs are able to provide comprehensive one-on-one assistance with completing LIS applications or enrolling in Part D plans. These organizations tend to be (1) large enough to be able to devote staff time to training and service provision, or (2) accustomed to helping individuals access public benefits and are therefore familiar with screening instruments used for means-tested programs.
- Some CBOs help identify potential LIS-eligible individuals. These are typically organizations that maintain client databases or, as mentioned above, routinely screen beneficiaries for other programs.
- Many CBOs provide meeting space for information and enrollment sessions that are produced by lead organizations. This is a typical role for small senior centers, for example. The centers may have staff on hand to help lead organizations quickly determine the likely LIS status of attendees. Similarly, organizations with a little extra office space or computer workstations might offer that space on enrollment days.
- Finally, lead coalition organizations recognized the importance of having small, resource-constrained CBOs leverage their rapport with low-income beneficiaries. These organizations may not be able to conduct any of the activities just described, but they do have staff that can tell prospects, “You might be eligible for extra help paying for prescriptions. Here is the name and number of an organization *I know* that can help you.” To ensure that referrals are as numerous as possible, lead organizations provide basic Part D and LIS training to staff at these small CBOs so that they know whom to refer and to where.

F. HEALTH CARE PROVIDERS

Health care providers (such as “safety-net” hospitals, FQHCs, primary care clinics, nursing homes, health plans, and retail pharmacies) are important sources for sharing Medicare

information with beneficiaries and family caregivers. The assistance these providers offered low-income beneficiaries included helping formerly deemed beneficiaries apply for the LIS, and helping beneficiaries evaluate whether the Part D plan they used in 2006 would cover their drugs and be affordable in 2007. If not, some health care providers helped them switch plans or (in the case of pharmacists) worked with physicians to switch beneficiaries' drugs. Because of their potential importance to outreach, education, and application assistance for the Part D and LIS programs, we engaged pharmacists, physicians, nursing home administrators, and Part D plan sponsors in interviews and focus groups.

Pharmacists. Although pharmacists do not have formal responsibility for Part D outreach and education activities, some choose to involve themselves or are drawn into the process by beneficiaries or information intermediaries. Pharmacists who participated in focus groups had varying levels of Part D involvement, from proactive assistance to troubleshooting at the prescription counter (for example, if beneficiaries presented their Medicaid card after Part D took effect).

Pharmacists said that in the first year of Part D, they placed information and marketing materials in display racks, accepted invitations to speak at senior centers, and directed customers to local service agencies or to the Medicare website or Medicare's hotline. Some pharmacists provided in-store Internet access; many did not. Informal intermediaries in all of the case-study sites spoke of pharmacists who helped beneficiaries understand their prescription drug plan options and enrollment steps. Pharmacists either printed plan formularies for the beneficiary and informal intermediary to review together, or intermediaries would identify two or three good options and send the beneficiary to review them with their pharmacist. However, comments from our focus groups revealed that many felt ill equipped to provide customers with the level of assistance they needed; those who worked in chain stores seemed especially constrained for time to help beneficiaries. In contrast, independent pharmacists said they had greater financial incentive to retain Medicare customers by helping them more with Part D. Pharmacists at community health centers were most likely to view Part D assistance as "part of their mission."

In the second Part D benefit year, pharmacists were less likely than in the first to participate in outside speaking engagements. In addition, although the pharmacists continued to help beneficiaries from their position behind the counter, their stores were somewhat less likely to host in-store sessions to help customers enroll in Part D. Pharmacists seemed to welcome the overall decline in demand for Part D assistance. As in Phase I, they commented that, although they sincerely wanted to help customers, they did not want the responsibility of helping people make decisions about their insurance, and they are busy with regular duties. Although several pharmacists said they attended training sessions about Part D in preparation for the first enrollment period, they now seek information only when necessary to answer specific questions. Medicare's toll-free telephone helpline for pharmacists, the CMS website, and internal resources were the most commonly cited sources of information.

In the second year of Part D, a new idea emerged to secure pharmacists' help with outreach. Several expert and stakeholder respondents told us of local outreach organizations that set up separate hotlines so pharmacists could assist their customers. The local outreach organization's Part D counselors would then respond to the pharmacist calls by going to the pharmacy to help in person.

In the focus groups, pharmacists described the questions they most commonly heard from low-income beneficiaries during the 2007 benefit year. Most were from people who had already enrolled in Part D plans, rather than from those who were newly eligible for Part D or who had heard about the Part D and LIS programs for the first time. Thus, pharmacists in the second benefit year were not assisting with enrollment decisions or informing beneficiaries of LIS as much as they were answering questions about co-pays, formularies, and the donut hole. Pharmacists said these concepts, and the relationship between doctors, pharmacists, and Part D plans, are confusing for many individuals. Some, for example, do not understand why their doctors would prescribe medicines not included in the formulary of their Part D plan. In addition, a pharmacist commented that continuously getting mail about Part D (from the government or Part D plans) “keeps beneficiaries agitated.” Many present their mail to the pharmacist to ask whether they need to take some action.

Pharmacists responded to individuals’ questions in a number of ways. When questions demanded straightforward, matter-of-fact answers, pharmacists answered them. However, when judgment was required (for example, about Part D plan choice), some pharmacists referred beneficiaries to CBOs they knew of or to the Medicare helpline (although some pharmacists hesitated make referrals to the helpline because they said they believe people dislike its automated aspects, may have to wait for an operator, may not get high-quality service, or are distrustful of a government-operated helpline.) Finally, as we heard from pharmacists in Phase I, several in Phase II said they often worked around formulary exclusions not by advising beneficiaries to switch Part D plans, but by working with doctors to change beneficiaries’ medications to those covered by the individuals’ current plans.¹⁴

As for LIS, at least one pharmacist in each focus group had not heard of it. Among the others, a few said beneficiaries ask them about it, and a few said they encouraged or helped beneficiaries apply for the subsidy. However, only the pharmacist in our focus group who was associated with a hospital outpatient department said she spent a considerable amount of time helping beneficiaries apply for LIS.

Physicians. Physicians do not have formal responsibility for Part D outreach and education activities, but they have often been promoted as potentially important players in this work because of their personal contact with beneficiaries, and beneficiary trust in their advice. However, in contrast to pharmacists, the eight physicians we interviewed by telephone in Phase I seemed to have deliberately limited their involvement in Part D issues. They understood the key components of Part D, and most made brochures available to their patients and referred them to 1-800-MEDICARE for answers to questions. The physicians rarely, however, engaged in consultation with their Medicare patients about what Part D or LIS is and which plan to choose. Some physicians said this was because other medical issues took priority during office visits.

In the second year of Part D, a potential new way to involve physicians in beneficiary outreach and education emerged. A local outreach organization encouraged physicians to participate more actively in Part D outreach by hosting luncheons to discuss aspects of Part D

¹⁴ CMS guidelines instruct pharmacists not to provide decision support in plan choice at the dispensing counter or steer beneficiaries to particular plans.

that most directly affect clinical practices. Topics included variations in Part D plan formulary rules and the appeals processes that might help beneficiaries gain coverage for specific prescriptions. This greater knowledge, it was hoped, would generate greater willingness on the part of physicians to assist patients in understanding and enrolling in Part D.

Nursing Homes. Several nursing home administrators noted during focus group and telephone discussions that having residents enrolled in Medicare Part D provides important financial protection for the nursing home. While CMS guidelines encourage nursing homes to provide impartial information about Part D to residents and their families, they instruct them not to influence plan choice. For nursing home administrators, however, the guidelines create tension over how much guidance and direct assistance to give. On one hand, many administrators said family members expect nursing homes to handle Part D (and many other matters) for them. On the other, administrators know they are not supposed to steer residents or families to particular plans, and many other responsibilities compete for their time. In the end, administrators balanced expectations and obligations as well as they could. Many did this by referring families elsewhere (for example, to AAAs or SHIPs) for Part D assistance if they believed the families were sufficiently “empowered” or motivated to see the matter through. Others described various levels of Part D plan choice assistance. One nursing home serving a population of deemed beneficiaries “ran all residents through the CMS Prescription Drug Plan Finder and encouraged families to switch” to a more appropriate plan, if there was one. Another nursing home administrator said that, after the home made numerous attempts to contact family members, they documented the lack of response, and then enrolled the resident into a Part D plan or switched auto-enrolled beneficiaries to another plan. Others reported enrollment assistance somewhere in between.

Nursing home administrators targeted most of their outreach and education materials to family caregivers rather than to residents. Family members usually made decisions on residents’ behalf in other matters; moreover they are less likely to have cognitive or literacy problems than residents. Both of these characteristics make them suitable targets for education and outreach. Administrators mailed letters to family members, invited them to luncheons and seminars for more information, and hosted outside speakers. They also referred residents and family members to social workers on staff or affiliated pharmacists for individualized assistance. However, these efforts had limited success, according to our focus group participants. Ultimately, administrators had to “pursue many families one at a time and persuade them to make a decision.”

Only a handful of administrators said they actively helped beneficiaries apply for LIS or informed them of its availability; many seemed only dimly aware of the subsidy. This is probably because a large proportion of their residents is dually eligible for Medicaid and receives LIS without having to apply for it. Most nursing home administrators in our focus groups said that the majority (65 to 80 percent) of residents in their facilities are dually eligible for Medicare and Medicaid.

Administrators expended great effort on education and enrollment assistance during the first Part D enrollment period. Subsequently, however, they have narrowed their focus to the enrollment of incoming residents. By the time we spoke with nursing home administrators in Phase 2, many had made Part D enrollment part of their routine admissions process. By taking the opportunity to deal with Part D while they have the attention of new residents and family members, nursing homes avoided having to reach out to them later. In the second year of Part D,

nursing home administrators said questions from family members of current residents most commonly arise when notices arrive in the mail about changes in formularies or preauthorization requirements.

On the other side of the coin, family caregivers who participated in focus group discussions said they received letters about Part D from the nursing home, and some had attended presentations there. They reported hearing about or seeing Part D on the radio or television, or in newspapers. Many recalled the handbook *Medicare & You*, and some knew it included a section written especially for them. Many of them called 1-800-MEDICARE, but most said they found it too difficult to reach someone with whom they could talk personally. Several tried to use the CMS Prescription Drug Plan Finder and had mixed opinions about its usefulness. One person commented, “It’s not in plain English.” The most favorable comments related to the individualized assistance that many received from the social workers on staff at nursing homes. “Everyone should have a social worker,” one said. No family member in any site reported feeling pressured by nursing home staff to choose one Part D plan over another. Overall, a slight majority indicated they were fairly passive and did not seek much information to make decisions on behalf of nursing home residents. The exceptions were those who had had to make Part D choices for themselves and so were more prepared to inquire about appropriate choices for the resident.

As for the enrollment process itself, roughly equal proportions of focus group caregivers said (1) their nursing home residents were auto-enrolled by CMS into a Part D plan, (2) the caregiver chose the resident’s Part D plan, or (3) the nursing home handled everything. Most caregivers said they were satisfied with how Part D enrollment was handled. A few, however, had negative experiences. One felt the government was rushing people to make decisions. Another felt the government was “telling him what to do” without providing enough support for decision-making; this person found Medicare helpline operators very lacking in knowledge. In addition, some said they welcomed it when nursing homes told them not to worry about Part D (because the facility or the government would select a plan), while others seemed to feel their concerns had been dismissed. Finally, few caregivers had heard of LIS or Extra Help, and none could say with certainty that their nursing home resident was receiving the subsidy. This, again, is probably because a large proportion of residents are dually eligible for Medicaid and receives LIS without having to apply for it.

Health Plans. In general, we did not hear from the field much involvement by health plan providers in Part D or LIS outreach and application assistance, except that plan marketing sometimes added to the confusion of beneficiaries. However, two of the stakeholders we interviewed were large Part D plan sponsors who said their organizations usually reach out to Medicare beneficiaries of all income levels. During the first Part D enrollment period, they had to decide whether to develop separate campaigns for low-income beneficiaries. Plan sponsors described difficulties we heard expressed by other stakeholders in identifying LIS-eligible beneficiaries who were not duals and automatically enrolled. These respondents spoke of trying to balance the desire to reach as many LIS-eligible beneficiaries as possible while not “stigmatizing” the entire Part D program as public assistance, thus turning off middle-income beneficiaries. Plan sponsors took varying approaches during the first enrollment year, with one mentioning LIS in all educational materials and another developing separate materials for low-income beneficiaries. Plan sponsors seemed to agree that it was more important to communicate

that Part D is available to *all* beneficiaries. One plan sponsor developed a step-by-step guide on how to apply for LIS, explaining each question in plain language.

The marketing methods plan sponsors used—mass mailings, radio spots, newspaper advertisements, and outreach at pharmacies, health fairs, and community presentations—are similar to the outreach and education activities reported by other stakeholders and CBOs. Plan sponsors have a clear interest in enrolling beneficiaries into their Part D plans, but one said that since the commission for enrolling LIS-eligible beneficiaries into a Part D plan is the same as for other beneficiaries, plan representatives did not differentiate between types of beneficiaries. In fact, in cases where individuals expressed concern about being able to afford a Part D plan, the plan sponsor said it was in the interest of the plan representative to enroll the beneficiary into the LIS so s/he would not lose the sale for Part D enrollment. The other plan sponsor relied on community advocacy organizations to enroll people into LIS and focused on Part D enrollment instead. This organization said it also conducted extensive outreach to nursing home administrators who were often interested in bringing all facility residents onto one plan.

One Part D plan sponsor reached out to racial minority groups by enlisting the help of nationally prominent “key influencers” or role models in African American, Hispanic, and Native American communities. The Part D plan sponsor then leveraged its connection with the key influencer when it asked churches and other local organizations to do Part D outreach on its behalf.

IV. WHAT CHANGES IN OUTREACH AND ENROLLMENT ACTIVITIES OCCURRED FROM THE FIRST PART D BENEFIT YEAR AND WHY?

To focus on best practice activities taking place in the first and second years of Part D, our Phase 2 focus groups with intermediaries, expert/stakeholder interviews, and summer 2007 case study investigated whether strategies or activities for assisting beneficiaries changed after the first Part D enrollment period and, if so, why. We learned that, in the program's second year, most organizations continued to employ many of the same strategies used in the first year—though on a smaller scale. In addition, they kept intact the coalitions and work groups they had established. However, we did hear reports of some significant changes, as described below.

One explanation for the changes in activities was a corresponding change in the types of assistance beneficiaries needed between the first and second program year. The open enrollment period for Part D's first year that ended in May 2006, was marked by a flurry of activity that generally focused on all Medicare beneficiaries and the implementation of any effort that might be effective. Some organizations, such as the Access to Benefit (ABC) coalitions, SSA, SPAPs, and Medicaid agencies, devoted considerable effort to reaching out to low-income beneficiaries and promoting LIS, but most organizations (including SHIPs, AAAs, medical providers, nursing homes, pharmacists, national advocacy organizations, and CMS) provided application and decision support to all beneficiaries. In addition, many CBOs—although realizing that non-deemed low-income beneficiaries were likely to be the hardest to reach and most in need of intensive assistance—focused on helping Medicare clients of all income ranges because the level of general assistance being demanded strapped their resources to such a degree that focusing on a specific segment was not possible.

The second enrollment period at the end of 2006 was slightly calmer than the first, however, due to better understanding of the Part D and LIS programs by both beneficiaries and organizations providing assistance. For instance, several intermediaries said that by the second year, CMS regional office staff demonstrated increased knowledge about Part D and LIS. However, organizations had to deal with new issues, including the re-assignment of beneficiaries to a new Part D plan when the previous plan terminated or increased its premium beyond that covered by LIS, annual recalculation of LIS cost-sharing, and annual redetermination of LIS eligibility. Demand for assistance, therefore, slowed somewhat from the first year but remained high as beneficiaries faced new decisions.¹⁵

Second-year activities were also affected by what intermediary respondents often termed “mission fatigue” brought on by a very busy year of providing Part D and LIS training and assistance. Many respondents also told us that beneficiaries were less attentive to Part D messages and information during the second year of the program after hearing so much about it

¹⁵ In September of a given year, for instance, CMS and SSA mail a notice to all LIS beneficiaries whose current deemed status will end December 31 of that year. Even though these beneficiaries are no longer automatically eligible for the LIS, they still may qualify and the notice encourages them to complete and return an enclosed LIS application. Such beneficiaries, who were not required to apply to the LIS program previously, may need assistance in understanding the requirement and the application process.

during the first year. Intermediary respondents said that in the second year of Part D, beneficiaries were more likely to attend a presentation or pay attention to materials that addressed their holistic needs, combining Part D information with information on such other topics as retirement planning or changes in social security benefits.

Decreased CBO funding also impacted outreach and education activities in the second year of Part D. One national beneficiary organization with local affiliates said, “The federal government cannot expect local organizations to be able to continue Medicare outreach and enrollment activities without funding. Local organizations do not have the resources.” Several stakeholder organizations also regarded the future of ongoing funding from CMS for outreach and enrollment as uncertain, and this led to a lack of commitment to future such efforts by some.

A. SOME INCREASED FOCUS ON LOW-INCOME POPULATIONS

While special outreach is often needed for those potentially eligible for LIS, most beneficiaries still need to be educated about the Part D program. Older Americans continue to “age-in” to Medicare and some beneficiaries already enrolled in Part D may choose to switch plans. Therefore, despite the new emphasis on LIS, outreach and enrollment activities continue to be a mixture of LIS-focused and more general education about Part D.

About half of informal intermediary and health provider focus group participants, stakeholder respondents, and case study interviewees said they began to focus specifically on LIS in the program’s second year. Increasingly, they concentrated on outreach to beneficiaries who did not sign up for LIS during the previous year, new Medicare enrollees, and those who lost their deemed status and had to apply for LIS.

However, many other focus group and case study participants said they spent less time reaching out to potential LIS-eligible individuals in the second year than otherwise would have been the case because demand for assistance from Part D enrollees was so high. These were mainly new Medicare enrollees, beneficiaries who were reassigned to a different Part D plan by CMS from one year to the next, or beneficiaries who belonged to plans that changed their formularies or co-payment amounts, or withdrew from the Part D market. Nursing home administrators and pharmacists in our second-year focus groups also reported spending a lot of time during the second benefit year helping beneficiaries who had begun Part D coverage the previous year.

In general, however, many organizations continued to do both LIS and general Part D outreach. According to a national organization advising local Medicare coalitions, an estimated three quarters of local Medicare coalitions continue to do outreach for LIS. Many of the national organizations are still undertaking outreach to the LIS-eligible segment of the Medicare population as well. As with the general outreach, however, there are a few discouraged voices. One state outreach organization admitted that, “our sense is that those who we have not reached simply do not read literature or go to service agencies. If we can’t access them through typical channels, the only way to get them is by going door to door.”

B. INCREASED FOCUS ON REFERRALS

After the first Part D enrollment period, organizations still involved in beneficiary assistance wanted to ensure that other agencies or organizations serving the health care or social service needs of Medicare beneficiaries did not inadvertently drive off potential LIS-eligible individuals by an inability to help them. Therefore, to the extent that funds permitted, many organizations concentrated even more heavily in the second year on training community-based organizations (CBOs) and other professionals, such as social workers and home health care providers, on (1) how to help organizations recognize beneficiaries who might be eligible for LIS or wanted additional Part D assistance, and (2) how to make referrals to someone who can provide the needed information and assistance.

C. EMPHASIS ON COMPREHENSIVE BENEFITS

To address beneficiary and intermediary waning attention to Part D and LIS messages in the second year of the program, organizations modified Part D- and LIS-focused presentations to include discussions of broader Medicare program elements, a range of senior benefits, retirement planning, or new Medicare-covered prevention benefits. Many organizations also changed their strategy in the second year from focusing exclusively on Part D and LIS to offering low-income benefit check-ups to low-income individuals in order to maximize resources and improve beneficiary well being. They ran the BenefitsCheckUp program developed by NCOA, which screens for LIS eligibility while checking eligibility for other public benefits such as the Medicare Savings Programs, food stamps, or transportation vouchers.

D. GREATER USE OF ONLINE APPLICATION TOOLS

Intermediaries said they made greater use of technology in the second versus the first year of Part D. In particular, after noticing that SSA processes online applications more quickly (by several weeks) than paper applications, the intermediaries switched from helping beneficiaries file paper LIS applications to helping them file online applications. In addition, several intermediaries commented that the CMS Plan Finder tool seemed more user-friendly in the second year than when first introduced. However, none said that beneficiaries themselves were using the online tools with any greater frequency than before.

E. ATTENTION TO DEVELOPING STEADY-STATE PRACTICES

Many organizations realized that they lacked the resources needed to maintain the intense level of activities characteristic of the first and second years; many also sensed they had already reached the majority of beneficiaries in some way. Therefore, they began to focus on developing steady-state practices that could be effective in coming years. These practices focused on incorporating Part D and LIS assistance into organizations' *routine* activities while targeting beneficiary subgroups that had likely still not been reached.

Incorporating Part D/LIS Application Assistance into Routine Activities and Curtailing Other Large-Scale Activities. Second-year focus group participants representing CBOs seemed fairly evenly split between those whose organizations had greatly curtailed Part

D-related activities during the second year (for example, because of loss of special funding) and those whose organizations had made Part D and LIS assistance routine organizational activities. According to these intermediaries, providing one-on-one application and enrollment assistance has, for the most part, become a low-volume, routine activity for CBOs that still offer it. For example, organizations like Cleveland's MetroHealth Advantage, Maine's AAAs, and New Mexico's Indigent Health Program of Doña Ana County had continual inflows of new elderly clients or applicants. As a matter of routine, these organizations asked new clients and applicants whether they participated in the LIS program and, if not, offered to help them apply. We were also told that many nursing homes now screen entrants for LIS eligibility. Some SPAP programs have also incorporated questions that screen for LIS eligibility into their applications and processes for other benefits. As one agency stated, "It's just one more question on their intake questionnaire—what are you doing for prescription drugs?" Additionally, others have folded LIS-screening questions into their SPAP application process; for example, New Jersey's pharmaceutical-assistance program now includes asset questions solely for the purpose of screening for LIS eligibility.

Furthermore, many outreach organizations now work with other social service agencies to screen for LIS eligibility at the same time the agencies screen for their own services. SPAPs, for example, screen possible clients for LIS at the same time they screen for the state program. AAAs also screen for the LIS at the same time that they screen for their social services. Other social service agencies refer the eligible individuals they have identified to Medicare-oriented organizations, such as SSA, the SHIPs, or the local ABC coalition.

The types of activities most likely to be curtailed in the second year of Part D/LIS were town hall meetings, large-group presentations, large-scale telephone banks, and mass-enrollment clinics. Even though some focus group participants said they planned to revive such activities during annual open-enrollment periods, they do not intend to conduct the activities throughout the year.

Focus on Specific Populations. For the most part, organizations still used lists of qualified leads, but some felt their usefulness was waning. For example, respondents from one case-study site who experienced a poor response to an LIS mailing in spring 2007 to individuals eligible for the Homestead Exemption from federal income taxes, believed they had reached many people eligible for LIS through that mailing, but not for the first time. Respondents believed some recipients of the mailing had probably already applied for LIS and that the others were not swayed into applying by one more piece of mail.

During our site visits, most organizations reported that not-yet-reached beneficiaries would require a more targeted approach – even as they acknowledged they were not sure what form the targeting should take or who the beneficiaries might be. Although some respondents said they had a pretty good idea of who some of the still non-enrolled low-income beneficiaries are likely to be and where they are located (e.g., the relatively isolated island communities in Maine), most said they were quite perplexed about who and why. For example, Atlanta GeorgiaCares believed its strategy of training more than 1,000 professionals to identify and assist people who are potentially eligible for LIS, along with its widely publicized helpline and community partnerships, should have reached the large majority of low-income beneficiaries. While respondents speculated that not-yet-reached beneficiaries have little contact with health or social service systems—and include homebound individuals, non-English-speakers, rural beneficiaries,

and mentally ill individuals—they had little hard evidence that such is true. Whether or not true, the case-study organizations were searching for innovative yet cost-effective ways to contact those not reached by earlier outreach efforts.

Several organizations shifted their outreach to families and caregivers of beneficiaries rather than to the beneficiaries themselves. One organization with this narrowed focus intends to do outreach to family caregivers by holding lunchtime meetings at the workplace for employees 55 years or older. Another organization is analyzing records on its retirees to identify possible contacts.

Additionally, some respondents said they would try to focus on subgroups for whom special content is still needed, such as dual-eligible individuals, individuals for whom English is not their native language and who might not be familiar with the U.S. health care system, and beneficiaries in need of unusual drugs. Examples provided included dual-eligible beneficiaries who need information to help them understand CMS’s auto-enrollment process and their rights to switch Part D plans. Immigrants unfamiliar with the U.S. health care system may need more than a translation of CMS materials; they may also require detailed explanation of such concepts as health insurance and comparison shopping explained. One respondent told us that deemed beneficiaries with certain chronic illnesses, such as multiple sclerosis, must become knowledgeable about plan formularies in case the formularies exclude the drugs they need. In addition, one respondent told us she had heard anecdotally that targeting the adult children of beneficiaries with cognitive impairments or literacy problems can be very effective because the children are less likely to have those problems themselves. Moreover, adult sons and daughters, unlike strangers, are qualified to make the value judgments necessary to choose a Part D plan on behalf of their parents.

Focus on New Outreach Partners. In the second year of Part D and LIS, several organizations turned their attention to partner organizations that might be well positioned to assist pockets of hard-to-reach beneficiaries. In one case, county extension agents from the U.S. Department of Agriculture or the National Grange attempted to reach rural beneficiaries. Veterans’ organizations have also become outreach partners in many areas. One new practice attempts to reach out to clients of free clinics on the belief that although these patients receive prescription drugs at low or no cost they might appreciate the more reliable SPAP and Part D programs.

F. CHANGES IN COMMITMENT TO OUTREACH EFFORT

Intermediaries said that by the second year, CMS regional office staff demonstrated increased knowledge about Part D and LIS, an improvement noticed by intermediaries when they called their regional office for assistance. In addition, a couple of intermediaries noted that, because their CBOs were involved in local coalitions formed around Part D and other Medicare benefits, they enjoyed access to SSA trainings and CMS regional office contacts that they would not have had otherwise.

Second year activities were also impacted by the perception—voiced by several CBO staff members in our Phase 2 focus groups and in the case study sites—that federal agencies and other organizations working at higher levels were promoting Part D and LIS less aggressively in the

second year and were less committed to keeping CBOs abreast of procedural changes. For instance, intermediaries commented that CMS regional offices were “coming to the community” and providing follow-up information about the state of Part D and LIS less often than in the past. These CBOs believed that without such support their assistance to beneficiaries was less. Similarly, informal intermediaries in one case-study site expressed dismay that, as they saw it, no higher-level agency seemed to be keeping Part D and LIS at the forefront of the national senior services agenda. They felt the federal government is expecting CBOs to do this, even though most CBOs have few resources to conduct wide-reaching outreach efforts. In addition, several stakeholder organizations believe the future of ongoing funding from CMS for outreach and enrollment is uncertain, resulting in diminished commitment on the part of some to future outreach and enrollment efforts.

V. OF THE MANY ACTIVITIES CONDUCTED, WHICH WERE DEEMED BEST PRACTICES FOR ENROLLING LOW-INCOME BENEFICIARIES IN PART D AND LIS?

A. BEST PRACTICES

Recognizing their nearly two years of experience in assisting with Part D and LIS enrollment amid changes in beneficiary demand, funding, and commitment, we asked Phase 2 focus group participants, expert/stakeholder interview respondents, and case-study participants whether they continued to regard the promising practices they had identified in Phase 1 as best practices in today's environment.¹⁶ Participants in these activities consistently identified the following as best practices for each step of the process from identifying potential individuals eligible for LIS application to Part D plan decision-making:

- **Identification**

- Use high-quality lists of qualified leads to identify potential beneficiaries who must apply for LIS (so-called non-deemed individuals); in the absence of such lists, use local safety net provider lists and lists from other low-income public benefit programs.
- Identify and educate beneficiaries by reaching out to them through their daily activities

- **Outreach and Education**

- Tailor advertisements and messages to local markets and local media
- Time community outreach to coincide with activities already planned for seniors, people with disabilities, and low-income persons in general

- **LIS Application Assistance and Part D Plan Decision Support**

- Provide comprehensive personalized one-on-one assistance
- Provide assistance through counselors that beneficiaries trust
- Provide assistance in the beneficiary's primary language

Below, we describe these best practices in greater detail.

¹⁶ As a reminder, we define "best practices" as activities, practices, or processes that led to identification, outreach, education, and enrollment of low-income beneficiaries in Part D and LIS and that appeared to use the most appropriate strategies for a given population and setting.

1. Identification

Identify Beneficiaries Through Local Safety-Net Provider and Public-Benefit Program Lists. Any organization with a mission to help enroll beneficiaries with lower incomes into Part D and LIS must first identify these individuals. Identification of those who are deemed eligible for LIS benefits due to their current enrollment in Medicaid, MSP, or SSI programs (i.e., those who do not have to apply for the LIS), is less problematic than for non-deemed beneficiaries. Full and partial dual-eligible beneficiaries can be identified through state MMA files, and SSI-only beneficiaries can be identified through SSA records. Although all of the organizations we talked with endeavored to reach out to non-deemed low-income beneficiaries, one of the biggest difficulties was how to cost-effectively identify who and where they might be. High-quality lists of potential LIS-eligible people (which would include individual beneficiary income and geographic location information, for example) clearly reduce identification costs over strategies that rely on broad-based outreach in the hopes that beneficiaries will self-identify.

The absence of reliable lists of qualified leads from organizations such as CMS, the Social Security Administration (SSA), or state agencies was often cited by formal and informal information intermediaries as a problem. Partnerships with community-based organizations (CBOs)¹⁷ and local safety net health care providers were generally seen as the next best way to identify beneficiaries potentially eligible for LIS who must apply for these benefits. CBOs and health care providers sometimes maintain lists they cannot share with others but that they themselves may use to identify low-income beneficiaries. One of the most useful sources is safety-net providers (for instance, Community Health Centers, Federally Qualified Health Centers, and community hospitals). As one example, the MetroHealth Medical Center, a key partner in the Greater Cleveland Access to Benefits coalition and the city's only safety-net hospital, collects financial information from patients to assign them a numeric rating used for billing purposes. The rating system aligns with LIS eligibility criteria so patients with a hospital rating of five or six would very likely qualify for the LIS, and patients with a four might qualify. During the period covered by this study, the hospital's MetroHealth Advantage program for seniors sent postcards to patients rated four, five, or six, offering them LIS application assistance. MetroHealth Advantage also asked the hospital's doctors, pharmacists, and billing specialists to send potentially LIS-eligible patients to its office.¹⁸ Similarly, in our case study of southern New Mexico, the Indigent Health Program (IHP) of Doña Ana County, a payer of last resort for health care claims, collects information on patients' income, assets, employment, and residency to determine eligibility for IHP benefits. During the first two Part D enrollment periods, IHP used the data to screen clients and new applicants for LIS eligibility and to encourage them to apply. Many of these patients may be so-called "hard-to-reach" beneficiaries who ignored LIS and Part D outreach when they were healthy.

¹⁷ We use the term CBOs in this report to include both formal and informal intermediaries serving a local geographic area, such as a group of counties, a single county, a city or town, or specific communities within a city or town.

¹⁸ Of additional interest is that although MetroHealth had access to a high-quality list of potential LIS eligibles, it reported spending most of its time (about 80 percent) on educating its clients about the benefits of the LIS program and motivating them to apply for it. Assistance completing the application itself accounted for only about 18 percent of its labor hours.

Many study respondents said they also made excellent use of lists from other public benefit programs—such as the food stamp program; local or regional energy assistance programs; food pantries; Meals-on-Wheels; and health plans targeted to low-income, Medicaid, or special-needs individuals—that serve populations similar to the LIS population. State governments may have access to lists for programs funded or administered by the state, such as for the Low Income Home Energy Assistance Program (LIHEAP), property tax rebate programs, and SPAPs. AAAs often have good access to such lists because they generally administer a variety of programs for older adults, including employment services, senior centers, congregate meals, adult day care services, in-home services, senior housing, and legal assistance. Some AAAs also house SHIPs, making them a natural information intermediary for Part D and LIS assistance.

Respondents used public-benefit program lists in a variety of ways: to prepare mailings to potentially eligible beneficiaries; to target specific communities for recruiting trusted neighborhood organizations to perform outreach; and to input data into a Geographical Information System (GIS)¹⁹ to identify locations at which to hold potentially fruitful outreach events. It is sometimes difficult for one organization to obtain confidential lists from others, however. One remedy is to partner with another CBO in outreach efforts, such as by including information about LIS on printed Meals-on-Wheels menus or enclosing Part D flyers in utility statements. As another example, a formal intermediary, such as a SHIP might offer to prepare outreach materials that the CBO is willing to send to its list of low-income individuals, or volunteer to train the CBO on the basics of LIS screening so callers can be referred to a CBO that can provide personalized LIS information and assistance.

Another approach is to offer “one-stop shopping” assistance at one agency or location for a variety of public benefit, health, aging, and disability programs, including Part D and LIS. As an example, Maine’s regional AAAs blend funds, co-locate, and cross-train staff from several programs that provide public benefits to seniors. When Medicare beneficiaries request assistance from one program, such as with utility bills, staff assess their eligibility for other benefits, including LIS.

Identify and Educate Beneficiaries by Reaching Out to Them Through Their Daily Activities. Many CBOs charged staff members or volunteers with identifying potential LIS-eligible individuals at sites and neighborhoods where low-income individuals typically congregate, including low-income housing complexes, food banks, grocery stores (on days popular with food stamp shoppers), faith-based organizations, and pharmacies (when free flu shots or blood pressure screenings were offered). As one local SSA representative put it, “There was a lot of hitting the road and reaching areas involved.” The Chicago suburban and Atlanta metropolitan case-study sites teamed with public hospitals to reach people with lower incomes and greater health care needs by sending outreach workers to the hospitals. Visits to these locations often proved more productive than conducting enrollment clinics at, for example, senior centers, which do not necessarily serve only low-income individuals. Some CBOs also engaged the caregivers of low-income beneficiaries by making Part D/LIS presentations at the

¹⁹ A GIS is a computer system capable of capturing, storing, analyzing, and displaying geographically referenced information; that is, data identified according to location.

worksites of companies that employ a large number of low-income workers. Finally, some organizations tried to find potential LIS-eligible beneficiaries through door-to-door canvassing of low-income neighborhoods.

2. Outreach and Education

Tailor Advertisements and Messages to Local Markets and Local Media. To increase beneficiary attentiveness and understanding of Part D and LIS education and outreach materials, messages should be customized to reflect the characteristics and preferences of the local community. Furthermore, we heard repeatedly that beneficiaries have greater trust in information delivered by local media—community or special-language newspapers, AM radio stations, and community-access cable television—than in messages appearing in national newspapers or on television networks, which are often perceived as “slick.” This is consistent with a Medicare Payment Advisory Commission study in which beneficiary counselors in one state reported that using local media was the most efficient way to inform homebound and rural beneficiaries about local programs (MedPAC 2008).

Time Community Outreach to Coincide with Activities Already Planned for Seniors, People with Disabilities, and/or Low-income Persons. A best practice approach to outreach and communications is to take advantage of scheduled local events. This might include, for example, conducting outreach at health fairs already organized by local senior centers.

3. LIS Application Assistance and Part D Plan Decision Support

Provide Comprehensive Personalized One-on-One Assistance. Experts and stakeholders, formal and informal intermediaries, case study respondents, and beneficiaries themselves said comprehensive and personalized one-to-one assistance is by far the best way to enroll low-income beneficiaries in Part D plans and apply to LIS. Both deemed and non-deemed low-income beneficiary focus group participants said the most useful assistance they received came from other people—including pharmacists, caseworkers, older beneficiaries, CBO staff, and SSA staff. From the perspective of beneficiaries, one-to-one application and enrollment assistance was undoubtedly the most useful practice because they found it to be the best way to address their individual circumstances. This finding is consistent with key findings from earlier studies that looked at best practices for enrolling low-income Medicare beneficiaries into other public benefits programs (see, for example, Haber et al. 2003 and Access to Benefits Coalition 2005).

Comprehensive assistance may consist of trained counselors who help beneficiaries complete a LIS application and then submit it to SSA for them or help beneficiaries use the CMS Plan Finder or similar online tool and then submit the plan choice to CMS. Personalized assistance may require a counselor to modulate his or her voice for a beneficiary with a hearing impairment, to explain the LIS application to a suspicious beneficiary in order not to stir fears about the government’s interest in the beneficiary’s assets, or to remind a generally reluctant applicant about the importance of insurance against unforeseen needs. One national advocacy organization we interviewed put it this way: “Enrolling in a drug plan is not something [seniors and those with disabilities] can do on their own...at the end of the day, beneficiaries need to talk to someone for help.”

One-to-one assistance appears to be important to individuals of all types, from those who are highly educated to those with cognitive impairments and health issues. Such assistance “allows consumers to express their particular concerns and challenges, allows a detailed response and connections to be made to other services and information they might need, even beyond Medicare,” according to one outreach organization. With one-to-one assistance, counselors can establish rapport with consumers and sift through complex problems. As an example, the CMS regional office that covers the Chicago area coordinated its outreach with AgeOptions (the AAA for suburban Cook County) by focusing its efforts on intermediaries rather than on individual beneficiaries. The regional office staff said they relied on the AAA and local SHIPs to work with beneficiaries one-to-one because those groups “are better equipped to handle” individualized counseling, while CMS is better equipped to handle educating large physicians groups, hospitals, clinics, and large employers.

Many of the study’s respondents emphasized that telephone assistance may be as effective as in-person assistance as long as the person delivering the help is knowledgeable and patient and the beneficiary does not have to navigate automated telephone systems. They noted, however, that telephone assistance usually takes more time and can make establishing rapport more difficult. For example, when counselors are entering the names of prescription drugs into the CMS Plan Finder tool, it goes more quickly if beneficiaries are present with their pill bottles, rather than spelling drug names aloud over the telephone.

A CBO’s decision to provide individualized assistance in person or over the telephone often depends on travel logistics. For example, transporting beneficiaries to enrollment events in rural areas was generally described as expensive and difficult. In some cases, telephone assistance can be more efficient than face-to-face assistance because neither counselors nor beneficiaries have to travel, and beneficiaries are home to access whatever records they need during the call. Telephone assistance was said to work better if the counselor, rather than the beneficiary, filled out the LIS application or the Part D enrollment forms (online or on paper) during the conversation. Beneficiaries do not always understand where on a form particular pieces of information belong, which can lead to anxiety on the part of beneficiaries and to errors.

Use Trusted Counselors. Many low-income beneficiaries not only require personalized assistance, but must receive it from someone they trust. MedPAC also reported that Medicare beneficiaries prefer to get information through personal contact with trusted sources (MedPAC 2006). Applying for assistance means divulging personal information about income, assets, and prescription drug needs. An example: although CMS and SSA provide toll-free helplines, none of our case study sites referred beneficiaries to them (although staff at some CBOs said they sometimes call the helplines on behalf of beneficiaries) because beneficiaries are usually more comfortable disclosing financial and medical information to counselors they know or with whom they share a common trait. In addition, we frequently heard that beneficiaries respond best to messages and materials associated with organizations they trust. All the local SSA offices and SHIPs we spoke with said that partnering with CBOs that had already earned the trust of low-income Medicare beneficiaries was an effective way to engage those beneficiaries. Following are several examples of how CBOs and others employed this best practice:

- To cultivate trust, one local organization ran a public service announcement in a community newspaper that included a photograph of a Part D counselor. When that

counselor made door-to-door home visits to beneficiaries, many recognized her from the announcement and welcomed her as a familiar face.

- “Having a trusted member of the community as an ambassador is one of the strategies with the most value. Training people within the community to take the message to people who are hard to reach is important,” said a staff member at a national organization of providers of outreach. Most of the organizations we interviewed reiterated this belief. Another respondent, a federal official, said, “Getting a knock on the door from an active social network minister is much more effective than getting a letter from the government.”
- Formal intermediary organizations can successfully identify trusted counselors by asking community leaders, even the mayors of very small towns, for advice. Study participants at various organizations told us these inquiries led them to enlist peer counselors in African American communities, *promotoras de salud* (laypeople involved in health outreach) in Hispanic communities, and church leaders in rural Southern communities.
- Local enrollment sites established especially for the introduction of Medicare Part D were the centerpiece of the Idaho MMA coalition’s effort. The MMA steering committee and regional coalitions established 140 enrollment sites throughout Idaho for the first open-enrollment period at libraries, senior centers, pharmacies, assisted-living facilities, nursing homes, and other community venues.

The need for trusted messengers was particularly acute for some beneficiary subgroups. Most Hispanic beneficiaries, we were told, are more likely to trust information they receive from CBOs than from government agencies. Thus, the national Hispanic organization we spoke with focused its efforts on coordinating and supporting the work of Hispanic CBOs rather than SHIPs.

Provide Assistance in the Beneficiary’s Primary Language. Obtaining assistance in their primary language can be very important to beneficiaries. This finding is consistent with other studies that stress the importance of having outreach specialists who know the language or local dialect (Glaun 2002 and Hoover et al. 2002). CBOs that serve specific ethnic or immigrant communities often employ staff who can communicate with beneficiaries in their preferred language or they access low-cost translation or interpreter services. We saw examples where CBOs recruited bilingual community volunteers, as well as students and professors from local colleges, to assist non-English-speaking beneficiaries.

B. CROSS-CUTTING ELEMENTS TO SUPPORT BEST PRACTICES

One of the most important findings that stands out across all of our research was that three fundamental elements improve the chances for any of the best practices respondents identified to be effective:

1. Strong reliance on CBOs to “do the heavy lifting” of reaching out to, educating, and providing one-on-one assistance to beneficiaries from trusted advisors

2. Establishment of a comprehensive infrastructure of broader-based organizations with a national focus (for example, CMS and Social Security Administration (SSA) central offices and advocacy organizations such as Families USA and AARP), a regional focus (for example, CMS regional offices), or state focus (for example, Medicaid agencies, state aging departments, and state SHIP offices) to support CBO efforts
3. Formation of inclusive and cohesive formal and informal partnerships to create the necessary links among CBOs and between CBOs and broader-based organizations

Additional details on each of the three follow.

1. Rely on Community-Based Organizations to Implement Best Practices

An oft-repeated refrain from individuals and organizations participating in our research was that “working through CBOs” is one of the best ways to address many of the challenges of enrolling low-income beneficiaries in a Part D plan and LIS. Unlike agencies that cover a broader geography, CBOs (both formal and informal information intermediaries) generally succeed in arranging and performing outreach and enrollment activities *that are visible to or directly involve beneficiaries*. This is consistent with studies of earlier benefit programs for low-income Medicare beneficiaries, including the Medicare Savings Programs and the Medicare Prescription Drug Discount Card and Transitional Assistance Program, that found that partnerships with local groups and community providers were key to effective outreach and enrollment (see, for example, Glaun 2002 and Hoover et al. 2002).

CBO success reflects two realities: (1) CBOs are often best situated geographically to provide the one-on-one assistance needed and desired by most beneficiaries; and (2) the most effective outreach and enrollment activities are often context-based and take advantage of the enabling infrastructure (such as assistance with strategy development and training), with which CBOs have more familiarity than broader-based organizations. One national federal agency respondent told us, for example, that the key to its outreach success in the first year of Medicare Part D were the flexible grants made to their community-based partners in hard-to-reach areas. The agency did not dictate how the grants were used with the exception of setting broad guidelines in terms of expected enrollment assistance. So, for instance, in Montana, where gas was very expensive and the journeys to assistance sites often very long, the CBOs used the grant to buy gas cards to meet their counseling goals. In the rural counties of Florida, the lead CBOs worked closely with local libraries.

Once the supporting infrastructure is in place, CBOs provide a vital link for connecting low-income beneficiaries to the prescription drug benefits for which they are eligible. CBOs may fulfill many roles in effective implementation of the best practices we identified, including at least the following:

- ***CBOs Can Identify Beneficiaries Through Public Benefit Program Lists.*** CBOs often maintain client lists they cannot share with others but that they themselves may use to identify low-income beneficiaries. Examples include information on Meals-on-

Wheels clients, home health care clients, or residents of an adult community who receive subsidized housing.

- ***CBOs Can Identify and Educate Beneficiaries by Reaching Them During Their Daily Activities.*** CBOs often have considerable familiarity with the places where potentially eligible beneficiaries frequently gather, feel comfortable, and are likely to be receptive to learning about Part D and LIS. Beauty parlors, social centers, and congregate meal sites were frequent examples. Moreover, CBOs typically know a great deal about their client base. For example, in a small town in New Mexico that we visited, we learned that Hispanic beneficiaries prefer one senior center and that white, non-Hispanic beneficiaries prefer another. A regional organization might host a bilingual information session at one or the other center, but a CBO familiar with the town's seniors would recommend a session at each. As another example, AlphaOne—a Center for Independent Living for people with disabilities and a key partner in the Maine Medicare coalition—did outreach at the “social clubs” in the urban areas of Maine where younger disabled Mainers often go for entertainment and information.
- ***CBOs Can Provide Insight into Strategies Most Likely to Work Locally.*** CBOs also can provide considerable insight into outreach and education strategies most likely to work for their local community or constituents. An example of CBO usefulness in helping design outreach and education strategies came from our Atlanta case study. Staff in the Atlanta site of Georgia's SHIP (Atlanta GeorgiaCares) knew volunteers and beneficiaries would be reluctant to negotiate Atlanta's traffic congestion and parking problems to travel to their downtown office, so they drafted strategies that relied heavily on a centralized SHIP call center and state-wide toll-free number that routes callers to the nearest SHIP site. It married this activity with a decentralized, “cascading” plan that called for training hundreds of area intermediaries who have contact with Medicare beneficiaries so the intermediaries could provide in-person assistance, train other professionals in their communities, or make referrals to the SHIP helpline.
- ***CBOs Can Help Tailor Advertisements and Messages to Local Markets and Local Media.*** CBOs can effectively tailor messages to their local community's characteristics in ways broader-based organizations often cannot. For example, “extra help,” the term for the LIS benefit promoted by CMS and SSA, works very well in some areas. But in Maine, the Access to Benefits coalition approached the audience from the perspective of saving money for family events or for children or grandchildren. The coalition initially tried to use the “extra help” phrase, but found it did not work with Mainers, who seem to be culturally opposed to accepting extra help and reluctant to take benefits from someone who may be more needy. In contrast, in Idaho's MMA coalition outreach, the LIS program was always referred to as “extra help” or “extra financial help” to avoid stigmatizing the program, and they found this resonated well with Idahoans.

Additionally, compared to broader-based organizations, CBOs can customize outreach materials and messages to reflect the characteristics and preferences of the community and often can obtain media time or space for reduced rates or for no charge at all. Examples include The Center for Pan-Asian Community Services in

Atlanta that publicized LIS on local Asian-language radio programs, on local TV stations, and in several local Asian-language newspapers at no cost; the Fairhill Center for senior services in Cleveland that arranged for its program director and the director of the Cleveland Department of Aging to discuss LIS on a senior-oriented cable television program, “Golden Opportunities”; and the Maine ABC coalition that produced its own TV ads that were played statewide and on community-access channels, often for free. Many Maine respondents said this was an especially effective method to reach the rural population and homebound individuals, given the size of the state, whereas getting brochures and flyers into the hands of the target audience was not feasible. On the opposite spectrum, one respondent in Atlanta said radio outreach may not always be the best avenue for reaching Hispanic beneficiaries—although we were told it often is—when signal strength is low and serves a very limited area.

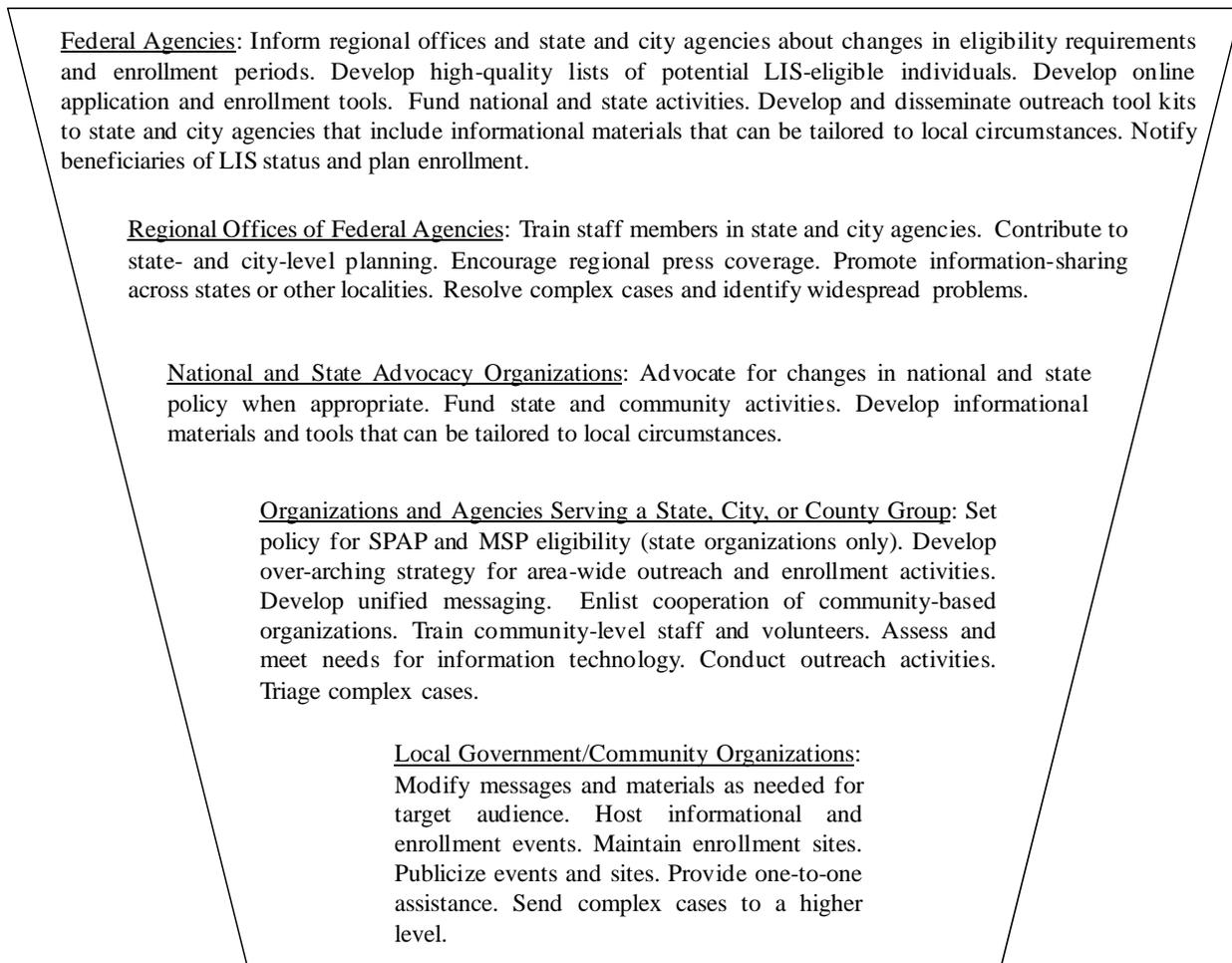
- ***CBOs Can Time Community Outreach to Coincide with Activities Already Planned for Specific Beneficiary Populations.*** With sufficient resources, CBOs are well situated to pursue an “opportunistic” approach to outreach and communications, taking advantage of already scheduled local events. For example, on May 15, 2006, in Cleveland, Ohio—the last day of the enrollment period for that benefit year—Jesse Jackson addressed the congregation of Cleveland’s most prominent Baptist church at the invitation of the pastor. Jackson’s appearance received little publicity; in fact, the SSA public affairs specialist learned of the appearance that morning while listening to the radio. But immediately upon hearing Jackson would appear, the specialist contacted the church, which offered him the opportunity to speak about LIS to the congregation. With encouragement from the compelling Jackson, people apparently conquered their usual reluctance, and the SSA specialist had his most successful enrollment ever.
- ***CBOs Can Provide Comprehensive Personalized One-on-One Assistance Through a Trusted Counselor.*** All the local SSA offices and SHIPs we spoke with said partnering with CBOs that had already earned the trust of low-income Medicare beneficiaries was a very effective way to engage them. In addition, CBOs are often more easily reached on public transportation.

2. Develop Infrastructure of Broad-Based Organizations to Support CBOs in Implementing Best Practices

Another consideration in making practices work effectively for Part D and LIS beneficiaries involves developing a strong infrastructure—financial and non-financial—that can support CBO implementation of the best practices described above. Many CBOs lack the time, financial resources, or technical skills to work in isolation from organizations that cover a broader geography, and can make excellent use of strong partnerships with federal, state, and local government agencies; politicians; and aging and disability service organizations. Below, we describe the necessary building blocks of the infrastructure and identify the types of organizations best suited to each infrastructure component, according to our expert/stakeholder respondents, formal and informal intermediary focus group participants, and case study respondents. (Figure V.1 organizes the components by the type of organization.)

FIGURE V.1

TYPES OF ORGANIZATIONS INVOLVED IN OUTREACH AND ENROLLMENT,
AND THE TASKS EACH TYPE DOES BEST



Source: Phases 1 and 2 case study site visits, focus groups, and expert/stakeholder interviews.

Organization of Flow of Information Top-Down and Bottom-Up. To facilitate communication of important information, provide problem resolution, and offer technical assistance, information must flow both downward from national, state, and regional organizations and upward from CBOs. Keeping numerous organizations abreast of policy and procedural changes, clarifications, and strategic decisions is critical to the smooth implementation of outreach and enrollment activities. Without the proactive support of federal, regional, and state agencies and other organizations working at broader levels, many CBO respondents said they cannot help beneficiaries as effectively as they would like. Most of the sites we visited established pathways for communicating important information *down* to the community level (for instance, when state SHIP offices receive news from SSA and CMS regional offices, they pass it along to local SHIP offices, other important participants, and CBOs). This finding is consistent with past studies of state programs designed to increase MSP enrollment, where Hoover et al. (2002) also reported that establishing communication mechanisms was a key feature of these programs.

In addition to organizing the downward flow of information from national, state, and regional organizations, most of the case-study sites established chains of communication so CBOs could send questions *up* to broad-based organizations for technical assistance. This upward technical assistance approach is also consistent with expressed local preferences for and comfort levels with obtaining information and advice from local SHIPs and CMS regional offices versus CMS's national office. CBOs might be advised, for example, to direct questions to a local SHIP or AAA office. If that office does not know the answer, it contacts the state SHIP or Aging office, which, if necessary, contacts the CMS or SSA regional office, and so on. Some organizations, often state-level SHIPs, are responsible for disseminating answers to frequently asked questions.

Development of Outreach and Application-Assistance Strategies. Our research indicates that the development of outreach, enrollment, and communications strategies is often the responsibility of organizations operating at the state, city, or multi-county level. Such organizations usually draw on the expertise of larger CBOs, particularly SHIPs and AAAs, and sometimes on the expertise of CMS regional offices and SSA. Organizations operating at the state, city, or county level have the best vantage point for planning strategy, as they have a sweeping view of area resources yet are close enough to their clients or constituency to identify the most important potential barriers to enrollment.

Clear strategies are needed for a variety of matters, including whether one-on-one assistance should be centralized (for example, all beneficiaries are referred to the same telephone call center) or decentralized (all beneficiaries are directed to the enrollment site closest to home). A site's decision might depend on whether the service area is rural, suburban, or urban; the convenience of public transportation in the area; and existing local services. (For instance, some sites have long maintained useful call centers for general Medicare questions, but others have not.) Strategy also pertains to crafting and disseminating a message about LIS that reduces the perceived stigma described above.

With regard to message dissemination (for LIS and more generally), communications directors in CMS regional offices can help local organizations devise a strategy for pursuing media coverage from regional sources. Strategy is also needed to establish the rules of engagement for organizations, specifying the types of questions each organization should try to answer for beneficiaries, and the types of questions that should be referred to a higher level. This is consistent with a key finding from the Access to Benefits Coalition report, which described that coordination of the players and division of their roles improved outreach and enrollment (Access to Benefits Coalition 2005).

Development of High-Quality Lists of Potential LIS-Eligible Individuals. Identifying who might be eligible for LIS but not for automatic enrollment in the program was a time-consuming and costly undertaking for all the organizations dedicated to helping low-income individuals. CMS attempted to provide relevant lists to its partners, but our respondents generally said the lists were not sufficiently targeted to be very helpful because they did not indicate who, among those who were LIS-eligible, were still not enrolled. The lists included estimates of the number of Part D-eligible beneficiaries in a given county or ZIP code who lacked prescription drug coverage and were potentially eligible for LIS, however, they did not indicate how many of these people were still not enrolled in LIS.

The absence of useful lists prompted formal intermediaries and CBOs to devise strategies to identify LIS-eligible individuals. For example, they sought cooperation and lists from groups that serve primarily low-income elderly or disabled populations, such as Meals-on-Wheels or energy-assistance programs. They also developed media campaigns, mailings, flyers, and presentations—sometimes widespread and sometimes targeted to particular populations, such as racial and ethnic minorities—that promoted beneficiary self-identification (e.g., at beauty parlors, churches, doctors’ offices, and pharmacies). Finally, they partnered with organizations most likely to serve potential LIS-eligible persons and sought cooperation in screening and then referring individuals to places (such as Centers for Independent Living, caregiver programs, and legal aid programs) that could provide additional assistance.

While these strategies were all deemed useful for identifying potential LIS-eligible individuals, we consistently heard that they were resource-intensive, that is, their “wide-net” approach was costly in terms of outreach and enrolling individuals not automatically eligible for LIS. The Access to Benefits Coalition (2005) found that using lists of qualified leads resulted in lower enrollment costs per beneficiary, and emphasized that the time invested in qualifying the leads (removing those not likely to be eligible or those already enrolled, or working with a government agency to cross-reference the list against their income roster) saved time in outreach and enrollment efforts later.

Provision of Varying Levels of Program Training. After the first Part D enrollment period, many local respondents said they wanted to make sure they did not inadvertently drive off potential LIS-eligible people by telling them, “Sorry, we can’t help you select a drug plan or apply for LIS.” Therefore, some lead organizations adopted a “no-wrong-door” approach that permitted beneficiaries to obtain Part D and LIS information and assistance from any agency or organization serving Medicare beneficiaries’ health care or social service needs. As one respondent said, “Every community should have a goal of agencies working together. Otherwise, beneficiaries get disgusted with the system and turn away.” For instance, so as not to discourage beneficiaries from considering Part D or LIS participation, most lead organizations in the case-study sites devoted significant resources to training as many information intermediaries in CBOs and local health providers (such as pharmacists and physicians) as funds allowed on the basics of Part D and LIS. Smaller CBOs that lacked the resources to maintain in-house expertise referred beneficiaries to SHIPs, AAAs, local SSA offices, or other organizations with appropriate expertise.

A particular example of the no-wrong-door approach is “one-stop shopping,” in which beneficiaries are screened for a broad range of health and social services benefits, including LIS, through a single agency. The Maine AAAs blend funds from numerous programs that provide public benefits and social services for seniors (and recently for younger disabled beneficiaries through Aging and Disability Resource Centers (ADRC) grants), co-locate staff members for all these programs in a single office, and cross-train staff on all the programs administered by the AAAs. Respondents said that combining one-stop shopping with cross-training enhances staff awareness of problems that might be occurring in related programs.

Training the people who design and implement outreach and enrollment activities is clearly one of the most important infrastructure components. Not everyone, however, requires the same level of expertise. Staff at state, city, and county agencies and large CBOs were thought to require the most comprehensive training in the Part D and LIS programs. In these cases, CMS

Regional Offices often provided the training. In turn, the CBO often created condensed versions of the training programs for smaller CBOs and volunteers. The sessions were tailored to the activities particular organizations would perform and incorporated useful information about area resources. Some training session covered only the basics about the LIS and Part D programs, with an emphasis on where to refer individuals for one-on-one assistance.

Before the introduction of Part D, formal intermediaries such as the SHIPs and AAAs often relied heavily on volunteers to provide peer-to-peer counseling. They found that such counseling was one of the most effective ways of delivering one-on-one assistance to Medicare beneficiaries, so volunteers were a primary target of training sessions. However, several SHIPs and AAAs now make much less use of volunteers. The consensus among respondents was that very few volunteers can handle the complexities of the combination of Medicare Parts A, B, C, and D as well as related issues such as Medigap plans, employer-sponsored drug coverage, SPAPs, commercially sponsored free prescription drug programs, Veteran Affairs' health benefits, and Medicaid and MSP. It requires a great deal of intensive training to keep up with changing policies and a consistent presence in the office to follow up adequately with beneficiaries, and many respondents felt paid staff was much more suited to these challenges. Using paid staff to provide enrollment assistance and decision support was usually possible, however, only in organizations that could scale up quickly by securing funding for temporary staff and recruiting supplemental help in the form of what a respondent termed "sophisticated" volunteers, ones who are (1) computer savvy, (2) experienced in the health care field, (3) experienced in dealing with complex issues.

Provision of Appropriate Technological Infrastructure. The online LIS application (developed by SSA), Medicare Prescription Drug Plan Finder (developed by CMS), and BenefitsCheckUp (developed by NCOA) were essential components of the CBO assistance infrastructure. We frequently heard that comparison-shopping for a Part D plan is difficult without the Medicare Plan Finder or a similar Internet tool. Many low-income beneficiaries cannot access or use the online tools on their own, but organizations assisting beneficiaries used them daily.

The use of online application and plan-finder tools is impossible without a technological infrastructure, such as computers, Internet access, and printers. When Part D and LIS were introduced, low-income Medicare beneficiaries were not alone in lacking access to technology. Many small CBOs and even local government offices still had few or no computers with Internet access and many local respondents said that they expended considerable effort to obtain desktop and laptop computers with wireless Internet access and portable printers. Such technology was essential for local enrollment sites and home visits, where a great deal of one-on-one assistance was provided. The technology was usually funded from local or national grants, typically coordinated by state, city, and county agencies. Respondents emphasized that technology investments were not one-time purchases but required regular funding to update and maintain.

Development of Simplified, Targeted, Culturally Appropriate Materials and Messages. Beneficiaries in our focus groups frequently said that information about Part D was not presented comprehensibly. Written materials and oral presentations, they said, were difficult for beneficiaries to understand, owing to low literacy levels, physical and cognitive impairments, confusion about programs and benefits, and limited English proficiency. Both CBOs and such broader-based organizations as CMS, SSA, and State SHIP and AAA offices have roles in

ensuring that outreach materials, media announcements, applications, and software all present information simply and appropriately; details about Part D and LIS can be addressed through counseling or small group presentations. Responsibility for the simplification of beneficiary outreach materials might best rest with national or regional organizations with the resources to devote to materials development and consumer testing. CBOs could then tailor materials and outreach messages to their local community.

In addition to developing and simplifying materials, national or regional organizations might prepare materials for particular populations in non-English-language translation. Many organizations pointed out that written materials developed by CMS and available in English and Spanish were not useful to individuals with other primary languages. To compensate, some organizations (both CBOs and national in scope) translated written materials into other languages (especially Asian languages) and developed special content to explain unfamiliar concepts.

Further, several respondents discovered that informational presentations are more effective when the audience consists solely of beneficiaries in the same eligibility category (for example, whether they are deemed eligible for LIS or must apply for it) rather than when the audience includes everyone in a generic group (such as residents of the same housing complex). MedPAC also advocated this approach as a strategy for effective Part D enrollment (MedPAC 2006). With such an approach, materials and question-and-answer sessions can be tailored to the audience, and beneficiaries are more comfortable asking questions if they know that everyone else is in the same income stratum. Again, national and state organizations are probably best suited to developing the generic form of such materials, and CBOs can tailor them to their audiences.

An interesting application of targeting materials involved an Atlanta CBO that partnered with SSA, CMS, and the Georgia SHIP during large enrollment events to “triage” beneficiaries into different rooms depending upon their eligibility for different drug or Medicare assistance benefit programs. Upon arriving at the event, beneficiaries were given a set of color-coded sheets, each corresponding with the income and asset limits for a particular benefit program. Each sheet asked income and asset questions, progressing from the lowest to the highest level. Beneficiaries with the lowest level of income/assets filled out only the first sheet, which instructed them to go to the room with the same colored sign as the sheet. Beneficiaries with higher levels of income/assets were directed to move to the next sheet. Again, if beneficiaries had income/assets no higher than listed on this sheet, they would go to the appropriate room for assistance. In each color-coded room, assistance was given for a particular program. The process allowed people to identify their income and assets anonymously (only the CBO knew what the color codes meant) and to receive assistance with people who were in essentially the same situation.

3. Form Comprehensive, Inclusive, and Cohesive Partnerships to Connect CBOs to Supporting Organizations

The discussions above make it clear that partnerships in many forms and across many types of organizations are essential to increasing Part D and LIS enrollment and promoting informed Part D plan choice among low-income beneficiaries. National, state, and county governments should forge partnerships with private organizations, particularly at the community level, to achieve enrollment goals. In turn, CBOs must partner with broad-based organizations to access

the infrastructure necessary to effectively implement best practices. Many CBOs also networked with other CBOs to share information, resources, and referrals. The findings from our research provide lessons for strengthening partnerships; moreover, they point to partnership types not often seen before the introduction of Part D.

The Strongest Partnerships Are Mutually Beneficial and Involve Strong Leadership.

One finding relating to strengthening partnerships is that it is essential to reward all partnership members to foster continuing commitment to the partnership's work. In particular, a partnership should produce added value for each partner organization. For example, for a small or medium-sized CBO providing Part D and LIS outreach and assistance, the value-added from partnering with state agencies might be additional funding, contacts at CMS or SSA, access to a new forum for raising program awareness or beneficiary interests, or reliable problem-solving support. One of our case-study coalition leaders—AgeOptions—encouraged groups to join the Illinois Make Medicare Work coalition by offering funds, technical assistance and referrals, timely and credible information, access to CMS and SSA contacts, and the ability to deal with persistent problems on a systemic level through policy advocacy. To a federal or state agency, the main value-added from partnering with CBOs is the ability to connect with hard-to-reach beneficiaries. Other studies agree with this model of mutually beneficial partnerships (Lipson et al. 2007 and Glaun 2002). A poor model for lasting partnerships was for federal and state agencies to ask CBOs—particularly small ones with shoestring budgets—to simply add Part D and LIS responsibilities to their existing workload.

Maine's longstanding Maine Medicare Workgroup (MMW) underscores another important point about successful partnerships: strong leadership. The MMW was formed in 1998 to focus on Medicare issues through the initial efforts of the CMS Regional Office and State SHIP staff. The MMW built on Maine's long history of coordinating efforts among various state offices and of working closely with community groups for a variety of programs. The comprehensive group, hosted by the Maine SHIP, includes Maine Legal Services for the Elderly (LSE), each AAA in the state, the state Bureau of Elder and Adult Services (BEAS), the state Medicaid office, Catholic Charities, the Maine Primary Care Association, SSA representatives, CMS Regional Office representatives, AlphaOne (a Center for Independent Living), the state's Division of Mental Retardation, and AARP, among others. The well-attended MMW meetings serve many purposes, including providing a forum for introducing and resolving casework issues and airing and addressing "hot issues;" disseminating updated information on current Medicare program developments and other partners' outreach efforts; and bringing LIS or Part D systemic problems to the attention of local, state, or national agencies. Several respondents noted, however, that the need for strong leadership continues to be one of the main challenges associated with maintaining the operations of a large coalition such as the MMW. The state's BEA and Maine LSE consistently provide that leadership. The two agencies keep the coalition alive and active by writing grant applications, holding strategy sessions, hosting regular conference calls and meetings, creating agendas that are relevant and interesting to MMW members, and following through with MMW members to collect data and write reports.

New Types of Partnerships Formed for Part D. We often heard that while partnership-building is always difficult, the advent of Part D made it somewhat easier. A good example of this is the experience of Maine's MMW coalition. Maine case-study respondents stressed that many of the partnerships embodied in the MMW were well established prior to Medicare Part D or its predecessor Prescription Drug Discount Card program. But they also emphasized that Part

D helped to further cement the partnerships, and attracted new members from different agencies, such as AlphaOne (a Center for Independent Living), Maine’s DHHS Division of Mental Retardation, and Catholic Charities Maine. After the implementation of Part D, the MMW doubled from about 15 to 30-35 people, mainly because “people were desperate to find information about Part D.” As another example from our case studies, the Atlanta SHIP reported some initial resistance in obtaining agreement from other agencies to partner and provide outreach and enrollment assistance to their Medicare populations because GeorgiaCares was unable to provide any extra funding to them. However, ultimately many partners came on board, swayed by the realization that clients would require intensive assistance and that Atlanta GeorgiaCares’ resources were not sufficient to provide this to the more than 300,000 beneficiaries who live in the Atlanta area. In return for working with their client bases, Atlanta GeorgiaCares provided the Part D training and assistance these partners’ staffs needed. This pitch was also successful in convincing the local hospital systems to partner with GeorgiaCares.

In many cases, the need for additional reliance on partnerships led organizations and agencies that had not previously collaborated to work together for the common goal of providing comprehensive Part D and LIS assistance. For example, the Chicago suburb AAA realized that a commitment to reach the diverse population in their area would require going beyond the traditional partners in the Aging Network and contacting local agencies that already work with traditionally underserved populations, such as disabled individuals or non-English speakers. CMS itself also reached out beyond its network of state SHIPs to focus on the entire Aging Network as it became increasingly aware of its need to partner with other organizations. As another example, a stakeholder respondent said that “Medicaid had never been at the table with the local AAAs,” but “all of a sudden, halfway through the Part D outreach campaign,” local Medicaid agencies began to realize AAAs could be very helpful in explaining Part D to dual-eligible individuals, and in many places this connection was made. Important types of newly formed or forming partnerships mentioned repeatedly throughout our study include the following:

- ***Partnerships Between Service Providers and Policy Advocates.*** Regular interaction of direct service organizations with policy advocacy organizations can be beneficial to both. As one respondent emphasized, “One informs the other—you don’t know which policies you want to change unless you have experience on the street about what’s going on. ... In the other direction, when a new policy comes out, our education partners can get the word out very quickly.” A good example of a strong provider-advocate partnership is the one between Health & Disability Advocates (HDA) and AgeOptions (an AAA) in the Chicago Access to Benefits coalition. AgeOptions was able to identify systemic problems in the field and notify HDA, the coalition partner responsible for policy advocacy. HDA staff said the link between direct service organizations and policy organizations was also quite valuable to maintaining their coalition.
- ***Partnerships Between the Aging and Disability Networks.*** Partnerships with community providers of health and social services for younger disabled beneficiaries are essential for reaching this population who many respondents still believe are underserved. Historic divisions between the aging and the disability service systems, mainly attributable to different funding streams and oversight agencies, can be

overcome through formal and informal coalition building. Moreover, such divisions are likely to diminish in the future as many SHIPs and AAAs now receive funding through Aging and Disability Resource Centers (jointly funded by the AoA and CMS), which are designed to serve as integrated points of entry into the long-term care system. Many other organizations we talked with were also forming or planning to form new partnerships with agencies that serve disabled persons, such as Centers for Independent Living, local chapters of the Alzheimer's Association, and HIV/AIDS advocacy organizations.

- ***Partnerships with Elected Officials.*** Local, state, and national elected officials can all contribute to enhancing the effectiveness of a community organization by helping to promote or legitimize the organization's Part D efforts. In several instances, politicians provided leadership in coalition development, facilitated policy change, or helped shepherd funding requests through the legislative process. For example, the Maine governor's Medicare Part D stakeholder group—consisting of some members of the Maine MMW, as well as the state pharmacy and mental health associations—was one of the driving forces in making changes to Maine's state eligibility rules for MSP, as well as the state plan amendment to automatically enroll Maine's SPAP members into LIS (via MSP). Interview respondents in Idaho identified strong politician involvement as one of the main reasons the Idaho MMA coalition worked well in 2005 and 2006. The Idaho MMA steering committee had the governor's imprimatur and was chaired by someone (a state legislator) not affiliated with the three key state-sponsored agencies on the MMA steering committee. Being in the governor's line of vision spurred the coalition's desire for success. And being led by an outsider helped organizations avoid the "turf wars" that often hamper intra-agency collaboration.

VI. WHAT FACTORS IMPACT THE EASE OF REPLICATING, DISSEMINATING, SUSTAINING, AND EXPANDING BEST PRACTICES?

A. REPLICATING BEST PRACTICES

Throughout our two years of research, we identified a core set of best practices consistently championed by national, state, and local organizations, information intermediaries, health care providers, and beneficiaries themselves. Our case study confirmed that the core set of best practices *can* be replicated in any community in the United States. However, it also clearly underscored that the details on *how* such practices are to be implemented are highly dependent on community characteristics and other contextual factors (Table VI.1). The practices worked because they were appropriate for the intended audience, the geographic environment, the social service systems, and the relevant enabling infrastructure.

TABLE VI.1
CONTEXTUAL FACTORS RELEVANT TO REPLICATION

Target Population	Geographic Environment	Social Services System
Attitudes toward government	Size of geographic area	Organization of major state, county, and city government agencies
Knowledge of health care system	Urban, suburban, rural area	Organization of the aging services network
Size of target population	Ease of travel	Experience with collaboration
Demographic characteristics	Types of community venues popular with low-income seniors or people with disabilities	Funding sources

Source: Case-study site visits conducted in August 2007.

Target Population. Beneficiaries in different target populations (such as immigrant communities, young adults with disabilities, and ethnic communities) may react quite differently to communications from government agencies and the introduction of new public benefits, and their reactions will affect the success of outreach strategy. For example, many people told us during site visits that, as a group, Hispanic/Latino beneficiaries might tend to be suspicious of government agencies. As a result, beneficiaries in this group may be less receptive to hearing about Part D and the LIS from CMS and SSA than from a trusted non-government source. This is consistent with an earlier study that found that distrust of government and unwillingness to disclose personal circumstances are particularly strong in many ethnic communities (Hoover et al. 2002). The Alivio Medical Center in Chicago, for instance, believing this to be the case, distributed outreach materials directly to its clients. As another example, coalition members in Idaho said they found it effective to refer to LIS as “Extra Help” or “Extra Financial Help” to avoid stigmatizing the program. In contrast, the “Extra Help” was thought not to resonate in Maine. Outreach strategists there thought “Extra Help” would bump against inherent pride and

reluctance to accept benefits that others may need more. Maine AAAs, therefore, promoted LIS as a way to save money for family events or grandchildren, rather than spend it on prescription drugs. Whether pride truly is stronger in Mainers than Idahoans is less important than the fact that the AAAs thought carefully about a message that would be well received in their state.

Individuals' familiarity and comfort with the U.S. health care system also will affect the success of outreach and enrollment strategies. Groups such as immigrants, who may be unfamiliar with the concepts of insurance, co-payments, and so forth, should be expected to require more one-on-one assistance and encouragement than others. The size and degree of isolation of a group also affect strategy effectiveness. For instance, Atlanta GeorgiaCares relies on a partnership with Center for Pan-Asian Community Services (CPACS) to reach Korean, Vietnamese, and Chinese beneficiaries, but not East Indians. The main reason is that the East Indians are more likely than beneficiaries in the other groups to speak English well and therefore require fewer specialized services (like interpretation). Specialized community-based organizations may not exist, so a better strategy may be to recruit individual community leaders to assist with outreach and enrollment activities. An earlier study described that outreach workers sought permission and support from tribal leaders and respected elders before conducting outreach on Indian Reservations (Glaun 2002).

Geographic Environment. The size of the geographic area as well as the urban or rural character of it, affects whether a particular outreach strategy will work in one area compared to another, a finding also described by the Access to Benefits Coalition (2005). In the more urban areas of Maine, for example, AAA hosts "Welcome to Medicare" birthday parties for groups of new 65-year-olds. The population is dense enough and transportation easy enough that attendance at the parties is good, and the AAAs have built Part D and LIS into the agenda. In rural Maine, by contrast, the birthday parties attract too few people, so the AAAs look to piggy-back on other community events (with a wider audience than new 65-year-olds) to speak about Part D. Meanwhile, in the Atlanta area, residents are so eager to avoid the traffic and parking problems downtown that they have grown accustomed to getting social services assistance by telephone. Thus, Atlanta GeorgiaCares made a toll-free telephone helpline its chief means of delivering one-on-one assistance to Medicare beneficiaries applying for LIS or enrolling in a Part D plan.

The replicability of some of the effective practices depends in part on the physical resources available in a given city or community. The coalition of organizations that designed a Part D and LIS outreach strategy for greater Cleveland, for example, used public libraries for information and enrollment events, as no resident lives more than a mile from a branch of the public library system in that city. In the urban areas of Maine, there are several "social clubs" where young adults with disabilities often go to "hang out." AlphaOne, a Center for Independent Living for people with disabilities, knew the clubs would be a good place to conduct outreach activities for the Part D and LIS programs. Replicability of this particular approach can occur only where such clubs are common. Again, the importance is that AlphaOne made use of what it knows about its clients.

The Social Services System. The structure of governmental agencies and the aging network in a local area help determine whether a particular strategy is transportable from one community to another. A good example comes from the Idaho case study. The Idaho Department of Health and Welfare has seven regional offices, each headed by a regional director, and 23

field offices throughout the state. Regional directors were recruited by the steering committee of the Idaho MMA coalition to chair a coalition in their region. The regional coalitions were relied on to use their knowledge of, and presence in, their communities to convey the agreed-upon Part D and LIS outreach messages they felt were most appropriate. This governmental structure lent itself well to reaching local communities; states with different structures may need a more grass-roots approach.

Similarly, strategies that depend on a strong collaboration among federal, state and local government agencies, CBOs, and other key players may not be easily replicated in sites without a history of collaboration. The Maine Medicare Workgroup (MMW) is a good example of a coalition whose members have worked together for years to address various Medicare issues in the state. When the Maine Access to Benefits Coalition formed to promote Part D enrollment, its leaders came from the MMW. Although other case-study respondents in other sites noted that the advent of Part D made partnerships among stakeholders more critical and, therefore, often easier to form, coalition-building that can stand the test of time requires a lot of hard work, as well as strong and consistent leadership, which the MMW has mustered.

One of the most important factors influencing whether an activity is replicable is funding. In the Chicago area, AgeOptions and its partners greatly expanded their reach through the Make Medicare Work (MMW) coalition, which formed at about the time Part D was introduced. The MMW coalition was made possible by support from a national foundation, two Chicago-based foundations, and the Illinois Department on Aging. The organizations involved in the MMW coalition unanimously agreed that similar coalitions are replicable in other places. However, AgeOptions noted their good fortune in having the two foundations in the area that traditionally focus on aging issues and were instrumental in starting the MMW coalition. Each coalition member stressed that the partnerships depends on the lead members having sufficient funding—from local, state, federal, or foundation sources—to make the partnerships revenue-neutral for each participant.

B. DISSEMINATING BEST PRACTICES

Coalitions have been the most important avenue for disseminating Part D, LIS, and best-practices information. They can be especially conducive to effective intra- and inter-organizational communications and rapid dissemination of what seems to be working and not working. Coalitions—as opposed to the more general term “partnerships”—were groups of organizations committed, at least short-term, to working together toward a single goal through activities that included developing common outreach strategies and messages, communicating policy changes on a regular basis, and sharing best practices. Coalitions of like-minded organizations were formed or strengthened at the national level (for example, the U.S. Administration on Aging created the National Field Strategy Group, a coalition of about 30 national organizations that have local affiliates; CMS partnered with the Access to Benefits Coalition chaired by NCOA); at the regional and state levels (for example, CMS regional offices encouraged Medicaid offices to form coalitions with community agencies that could reach LIS-eligible individuals; the ABC coalition in Maine conducted much of its work through its historical involvement in the Maine Medicare Workgroup; the ABC grantee in Chicago organized the Illinois Make Medicare Work coalition; and the Idaho MMA coalition arose from a series of SHIP-convened meetings for service and advocacy organizations that wanted to

prepare for the introduction of the Part D and LIS program); and at the local level (for example, the several local ABC coalitions made up of CBOs).

The case-study sites operating formal coalitions typically scheduled regular meetings for coalition leaders (twice monthly was common during enrollment periods) and sent periodic emails and newsletters to other coalition members. They also spent considerable time strengthening and broadening the coalitions, because of their usefulness for discussing individual casework issues; airing and addressing “hot issues;” disseminating updated information on current program developments; sharing “best practices” developed by coalition members; tracking trends in program problems; and helping coalition members determine which local, state, or federal agency can best resolve an issue.

Outside of the formal coalitions, most national organizations said they typically communicated with their state and local affiliates, both before and during the Part D enrollment period, through periodic telephone conferences and electronic listservs. However, aside from cooperation between CMS partners and among national, state, and local affiliates of the same organizations, we heard little about information-sharing across organizations, except in the case of the stronger coalitions.

C. SUSTAINING AND EXPANDING BEST PRACTICES

Funding—Uncertainty and Fatigue Hinder Maintenance or Expansion of Best Practices. Consensus among the focus group and case study respondents held that funding reductions and ebbing energy levels were likely to make the level of effort expended over the past two years of Part D *unsustainable* in the future. Many spoke of the introduction of Part D as if it were an exercise in emergency response—an approach that would be difficult for staff and volunteers to sustain for long. Only a few of the organizations we spoke with had plans to expand their activities in the near future. Additionally, by the end of Part D’s second year, many contracts with CMS, national advocacy organizations, and foundations had expired or were about to do so. Most respondents did not know whether to expect another round of funding.

Local organizations were also uncertain about what role they should play in assisting beneficiaries with Part D plan choice given the costliness of the process and the alternative of auto- or facilitated enrollment for LIS beneficiaries. Several CBO respondents also expressed frustration that the flow of funds to SHIPs often stalled at the state level, and they also reported that the number of professional SHIP counselors was insufficient.

Implementation of Some Best Practices May Require Revision Under “Steady-State” Efforts. To compound the reduced-funding issues, we found that some strategies that worked well during high-volume periods of Part D and LIS enrollment may not be as effective or cost-effective during lower-volume, steady-state periods. Some of the best practices for the early years will likely need modification for steady-state conditions, particularly the large call centers and mass enrollment clinics set up by CBOs to assist beneficiaries with Part D and LIS. The main goal of many of the organizations was to get the word out about the benefit programs and help as many beneficiaries as possible, with only limited targeting of the traditionally hardest-to-reach beneficiaries. But the hard-to-reach are the people who are less likely to be currently enrolled in LIS and who are most likely to require resource-intensive identification and

assistance strategies that may not mirror *implementation* of some of the best practices identified for the early years of the program. The “wide-net” efforts may not be financially sustainable when enrollment levels off, or even effective for LIS-eligible individuals who have still not been reached.

A concrete example of the challenge of striking a balance between demand and supply of call center services is demonstrated by Cleveland’s Benjamin Rose Institute, which established a call center specifically to help beneficiaries apply for LIS and, to a lesser extent, choose a Part D plan. During the period covered by our analysis, the call center had to adapt to fluctuations in call volume. It employed about 10 paid operators when volume was high, during the six weeks of second open-enrollment period, and the equivalent of 1.5 full-time staff thereafter, when volume was low. The small staff struggled to meet demand, however, when call volume intermittently spiked because of off-cycle outreach activities such as television appearances by the director of the Ohio Department of Aging to promote the LIS benefit. It is not easy for such a dedicated call center easily to adjust fixed and variable resources to meet fluctuating demand.

Meanwhile, in rural Maine, AAAs incorporated LIS assistance into the services they offered through their existing local call centers. Although they still had to devote more variable resources to answering large call volumes during some periods of LIS/Part D activity, the fixed costs of running the call center were not a great concern because they were part of the AAAs’ normal operating costs. Atlanta GeorgiaCares also had to augment its call center resources significantly to handle the much larger demands on its helpline during the early months of Part D. But because Atlanta GeorgiaCares already had experience running a helpline and local beneficiaries were comfortable getting assistance by telephone, the organization was able to ramp up its efforts fairly quickly with the advent of Part D—mainly by paying staff to work overtime.

The lesson about the benefits of different strategies during high- and low-volume periods of LIS and Part D activity can be extended to other outreach and enrollment strategies. NCOA, for example, is currently funding some local coalitions’ Part D and LIS efforts through a performance-based incentive approach. Organizations in the Greater Cleveland Access to Benefits Coalition (GCABC), for instance, now receive \$70 from NCOA for every beneficiary enrolled in LIS, not a lump-sum grant as NCOA previously provided. During our site visits, we observed a mixed response among GCABC members to NCOA’s new payment approach. On the one hand, organizations such as MetroHealth Advantage stand to gain from the \$70 payment because its LIS enrollment activities are self-contained and may be easily incorporated into its daily operations and readily targeted to likely beneficiaries. In contrast, the Benjamin Rose Institute’s call center staff said that, given the projected decline in future calls for LIS assistance, the \$70 payments will be insufficient to sustain the necessary infrastructure.

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APPENDIX A:
DATA SOURCES AND STUDY LIMITATIONS

This appendix briefly describes each of the data collection efforts conducted for the best practices study. Discussion guides for our interviews with experts and stakeholders and with case study respondents, the state survey instrument, and focus group moderator guides are included in a separate Appendix B, available from CMS upon request to the study's project officer. Appendix B also contains lists of respondent organizations for expert and stakeholder interviews and the case study.

A. INTERVIEWS WITH EXPERTS AND STAKEHOLDERS

Between late May and early July 2006, MPR conducted Phase I semi-structured telephone interviews to acquire an understanding of the range of Part D outreach, education, and enrollment activities taking place at the national, state, and local levels. The 30 respondents included representatives from the following types of groups:

- National organizations serving, or advocating for, the Medicare population or subgroups
- State or local organizations serving, or advocating for, the Medicare population or subgroups
- National associations of providers of outreach and enrollment assistance
- Part D plan sponsors or firms that help health plans with dual-eligible outreach and enrollment
- Federal government agencies with a stake in LIS and/or Part D enrollment
- Independent experts involved in the study of Medicare, beneficiary education, and prescription drug benefits

We selected organizations that focus a major portion of their Part D activities on low-income beneficiaries or serve some other group of interest to the study (for example, beneficiaries' family caregivers or beneficiaries who are members of racial or ethnic minorities). Several organizations had formal partnerships with CMS and had received federal funding to help with beneficiary outreach, education, and enrollment. We identified appropriate respondents within each organization by consulting with CMS and our study advisers at Rutgers University and the Access to Benefits Coalition. Except for the independent experts, most respondents were executive or senior administrative staff members at their respective organizations. Their responsibilities were to develop strategies for outreach and enrollment activities and provide training and technical advice to those directly involved in implementing Part D activities.

We asked respondents to describe (1) the range of Part D outreach and enrollment activities their organization conducted, (2) the reasons their organization and affiliates pursued the strategies they did, (3) the messages being imparted to beneficiaries and their families, and (4) how those messages differed by beneficiaries' LIS-eligibility status.

Between March and April 2007, MPR conducted its Phase II semi-structured telephone interviews with representatives from the same groups listed above. In the second phase, we contacted the most appropriate, helpful, and active organizations among those we had previously interviewed, as well as other organizations identified through expert interviews or by study advisors. Rather than reporting on practices that had continued since the first Part D enrollment period, however, these interviews focused on changes that had occurred over the previous year and practices that respondents reported were particularly effective, whether new or continuing. MPR asked respondents to place emphasis on practices that focused solely on, or seemed to be exceptionally effective in, getting individuals to apply for the LIS.

B. SURVEY OF STATE AGENCIES

MPR designed and administered a state-based survey to identify the types of outreach, education, and enrollment activities each state was conducting from summer 2005 through fall 2006. We sent the survey to the 51 state Medicaid agencies, 51 SHIPs, and 24 SPAPs in the 50 states and the District of Columbia. These are agencies that we believed, collectively, would be able to provide complete and reliable reports on the wide range of activities underway in each state during the time period. The survey asked respondents to separate activities out, as much as possible, by the type of beneficiary targeted (such as full dual eligibles, MSP enrollees, SPAP members, institutionalized beneficiaries, and other LIS-eligible groups) and to list outreach activities targeted to professionals and other information intermediaries. In addition, the survey asked the directors of the agencies to (1) list and rate the effectiveness of different outreach and education activities in enrolling LIS-eligible beneficiaries, and (2) describe any collaboration with other federal, state, or local organizations.

We received a total of 84 completed surveys. Most of these (78 out of 84) were completed by a single agency (32 Medicaid agencies, 35 SHIPs, and 11 SPAPs). Six were completed jointly by two or more agencies. In all, responses covered the activities of 92 agencies in 48 states, including the District of Columbia. No agency from Hawaii, Mississippi, or West Virginia completed a survey.

C. CASE STUDY

Evidence collected during the first year of our study strongly suggested that the most successful outreach, education, and enrollment activities take place at the local level with the active involvement of CBOs. MPR conducted an in-depth case study in six different parts of the country to examine how the efforts of many types of organizations coalesced in different communities, and to identify activities and ways of working that appeared highly promising for overcoming barriers to helping low-income Medicare beneficiaries apply for the LIS and carefully choose a Part D plan. MPR conducted site visits for the case study in August 2007 in Maine, metropolitan Atlanta, greater Cleveland, the Chicago suburbs, southern New Mexico, and Idaho.

Site selection for the case study was based primarily on qualitative data. MPR identified 10 candidate sites based on findings from Year One data sources and recommendations from

stakeholders and independent experts we interviewed in March and April 2007.²⁰ We prepared a profile of each candidate site, including the reasons the site seemed worthy of study, as well as the organizations leading its outreach and enrollment activities; its demographic characteristics; its LIS enrollment levels in 2006; and our assessment of the feasibility of conducting focus groups of beneficiaries and professionals in the site (because to enhance the case study findings we conducted focus groups in four of the six sites ultimately selected). From the 10 candidates, CMS selected six sites. In finalizing site selection, CMS and MPR gave greater weight to compelling qualitative reasons for choosing a site than we did to LIS enrollment levels. Collectively, these sites represent promising Part D and LIS practices on a range of criteria, including geography, demography, type of organization leading Part D and LIS enrollment efforts, involvement of other organizational partners, and the particular strategies being used to promote participation in the Part D and LIS programs. Table A.1 provides an overview of the six case study sites.

TABLE A.1
OVERVIEW OF THE CASE STUDY SITES

Legal Services for the Elderly (LSE) Coalition
<p>Service Area: State of Maine</p> <p>Demographics: Largely rural state with a number of geographically isolated communities; mostly non-white Hispanic population, but with a substantial number of French speakers in northern Maine and significant American Indian population in several counties</p> <p>Lead Organization: Maine LSE provides free legal services and houses a state-funded Medicare Part D Appeals unit; LSE's five Area Offices are located within their local AAA; Augusta LSE office is a Medicare SHIP site</p> <p>Key Partners: Five regional Area Agencies on Aging (AAAs), Alpha One (a Center for Independent Living)</p> <p>Key Elements of Its Principal Strategy:</p> <ul style="list-style-type: none"> • Strengthening the infrastructure the coalition already had in place prior to Part D, which consisted of (1) partnerships in the long-standing Maine Medicare Workgroup, (2) co-location of a broad range of social services and aging network programs provided through the local AAAs, and (3) focused volunteer peer-to-peer counseling • Greater use of earned television commercials for outreach • Increased access to newer technologies, such as laptops and portable printers, to take advantage of online sites for public benefit program screening, LIS application, and Part D plan choice

²⁰ We also consulted with authors of a recent MPR study of SSA and state Medicaid agency LIS application processes (Lipson et al. 2007).

TABLE A.1 (continued)

Atlanta Regional Commission/Atlanta GeorgiaCares

Service Area: Ten counties in the Atlanta metropolitan area

Demographics: Primarily suburban and urban area; racially diverse population, with significant populations of African Americans and immigrants, particularly from Latin America and eastern and southeastern Asia

Lead Organization: ARC is the umbrella organization for all the planning departments for the Atlanta metropolitan area and houses the Atlanta AAA; Atlanta GeorgiaCares is a contractor to the Atlanta AAA to provide regional SHIP services.

Key Partners: ARC's 10 county-based agencies and eight specialty agencies that provide AAA services to specific communities within the Atlanta region; Atlanta's local hospital systems

Key Elements of Its Principal Strategy:

- Provide most Part D/LIS one-to-one assistance through Atlanta GeorgiaCare's telephone helpline
- Train Atlanta GeorgiaCare's partners and professionals already serving Medicare beneficiaries to also provide one-to-one assistance
- Provide technical support to partners and trained professionals as needed
- Educate additional professionals about the availability of the Atlanta GeorgiaCare's helpline to create a strong referral network; use statewide media to drive beneficiaries to the helpline

Greater Cleveland Access to Benefits Coalition (GCABC)

Service Area: Cleveland and adjacent counties

Demographics: Concentration on Cuyahoga County (includes Cleveland), a mostly urban area; diverse population with significant African American population

Lead Organization: GCABC is chaired by the directors of the Cleveland Department of Aging and the Western Reserve Area Agency on Aging.

Key Partners: Benjamin Rose Institute (senior health care and social services provider, aging research institute); Fairhill Center (senior services provider); MetroHealth Medical Center (safety net hospital); Golden Age Centers (social services agency for seniors); two Neighborhood Centers Associations (family-focused neighborhood-based centers and settlement houses)

Key Elements of Its Principal Strategy:

- Rely heavily on a telephone call center (operated by Benjamin Rose Institute) and on-site enrollment clinics (arranged by Fairhill Center) to provide one-to-one assistance
 - Coalition of 47 local agencies directs Part D and LIS questions from their constituents to the call center or to an enrollment clinic
 - Identify targeted lists of potential LIS eligibles using MetroHealth's and Golden Age Centers' client lists
 - Use paid advertisements, reverse 911 calls, telethons, and telephone referrals to identify Part D/LIS eligibles, raise program awareness, and direct beneficiaries to call center or an enrollment clinic
-

TABLE A.1 (continued)

AgeOptions Coalition
<p>Service Area: Primarily Chicago suburbs</p> <p>Demographics: Suburban and urban areas; racially diverse population with significant African American, Hispanic, and immigrant populations, particularly from Latin America and Asia</p> <p>Lead Organization: AgeOptions is the local AAA for the suburban Chicago area and is the leader of the Illinois Make Medicare Work coalition.</p> <p>Key Partners: Progress Center for Independent Living; health and disability advocates</p> <p>Key Elements of Its Principal Strategy:</p> <ul style="list-style-type: none"> • Identify and maintain partnerships with numerous local community organizations that can themselves provide beneficiary outreach and one-to-one assistance • Provide funding to over 40 of these organizations, and technical assistance to all of them • Trust local organizations to know how to reach their own communities most effectively • Rely on partners in the Illinois Make Medicare Work coalition to hold presentations and enrollment clinics
Benefits Counseling Program (New Mexico SHIP)
<p>Service Area: Eighteen counties in southern New Mexico</p> <p>Demographics: Mostly rural; significant Hispanic population, including immigrants</p> <p>Lead Organization: Southern regional office of Benefits Counseling Program (New Mexico SHIP) consists of a network of volunteer counselors and a small paid staff.</p> <p>Key Partners: No formal partners but numerous informal partnerships with CBOs throughout southern New Mexico</p> <p>Key Elements of Its Principal Strategy:</p> <ul style="list-style-type: none"> • Use a grassroots approach, with the regional SHIP coordinator in Las Cruces forging personal connections with local organizations to create a “lifeline” between the SHIP and the community • Rely heavily on SHIP volunteers located throughout southern New Mexico communities to provide one-to-one assistance
Idaho MMA Coalition
<p>Service Area: State of Idaho</p> <p>Demographics: Outside Boise, Idaho has largely rural; mostly white, non-Hispanic population. There is a substantial Hispanic population in counties near Boise.</p> <p>Lead Organization: MMA Steering Committee, chaired by State Representative Kathie Garrett</p> <p>Key Partners: Statewide Health Insurance Benefits Advisors (Idaho’s SHIP); Idaho Department of Health and Welfare (DHW, includes the state Medicaid division); Idaho Commission on Aging (the sole state agency designated to receive funding under the Older Americans Act)</p> <p>Key Elements of Its Principal Strategy:</p> <ul style="list-style-type: none"> • Create a strong coalition by asking each MMA Steering Committee organization to commit to pitching in whatever resources it could and ensuring that these resources complemented one another • Each of DHW’s regional directors chairs an MMA coalition in his/her region • Establish 140 enrollment clinics throughout Idaho to provide one-to-one assistance • Use PSAs, flyers and mailings, and paid advertisements to identify and raise program awareness

Source: Site visits conducted by MPR in August 2007.

All site organizations agreed to participate in the study. The lead organizations in each site identified key partner organizations or individuals who could provide the most insight into activities at the site, and recommended specific activities we might want to observe, such as on-site enrollment clinics. We developed discussion guides for four types of respondent organizations, depending on the role the organization played in Part D and LIS activities:

1. Lead organization for the site
2. Key partner organizations, as identified by the lead organization²¹
3. Organizations not identified as a key partner in a particular site, but that typically have a formal role in outreach and enrollment for the Part D and LIS programs, such as state SHIP directors, local or state Area Agency on Aging (AAA) directors, and CMS regional offices
4. District-level SSA offices

Most data were collected during three-day visits to each of the sites. We typically interviewed 10 to 12 respondents while on site, and attended enrollment-related activities. We conducted most of our discussions with representatives of CMS and SSA by telephone before or soon after the site visit. Our discussions focused on activities the site organizations performed between June 2006 and August 2007. We chose this time frame, in consultation with CMS, to learn as much as possible about sites' steady-state outreach and enrollment activities, as opposed to activities conducted during the first, and most hectic, enrollment period.

D. FOCUS GROUPS AND TELEPHONE DISCUSSIONS

In Phase I of the study, we held nearly 30 focus groups and more than 40 telephone discussions with (1) community-dwelling beneficiaries who were, or were not, deemed eligible for the LIS, and with family caregivers of nursing home residents, (2) representatives of local AAAs, SHIPS, SSA offices, and community organizations; and (3) pharmacists, physicians, and nursing home administrators. Conducted from late June to early October 2006, these discussions provided perspective on respondents' experiences during the 2006 open-enrollment period, which ended May 15, 2006. Phase I focus groups were held in Columbia (South Carolina), Seattle, Indianapolis, and the Bronx. Our objective was to visit four different parts of the country and to select sites with fairly high concentrations of low-income elders and racial and ethnic minority groups. CMS asked us to include a site in close proximity to rural areas so that we could identify promising outreach and enrollment activities in such areas—Columbia was selected partly for this reason. The agency also asked us to include a site with a qualified SPAP so that we could learn more about the interaction between SPAPs and Part D, and this was a factor in selection of the Bronx. We eliminated from consideration any sites that had already been selected for another CMS study of the Part D program.

²¹ We used a modified version of the partners' discussion guide in several instances when we talked with individuals, such as SHIP volunteer counselors, about their activities and views on effective practices.

The 25 focus groups and 12 individual telephone discussions MPR held in Phase II were designed to complement the case study of best practices. By design, the groups were similar in composition to those participating in Phase I. Specifically, our discussions between July and October 2007 were with beneficiaries who applied and were approved for the LIS in 2007 or who were deemed eligible for the subsidy because they receive Medicaid or certain other public benefits. Our other discussions were with representatives of CBOs; nursing home administrators and residents' caregivers; and pharmacists. With resources to conduct focus groups in four of the six case study sites, MPR and CMS based site selection for the focus groups on preliminary estimates of the number of LIS participants in areas of high population density, and our knowledge of the availability of senior services in the area. CMS ultimately selected Albuquerque, New Mexico; Atlanta, Georgia; Augusta, Maine; and Chicago, Illinois as the focus group sites.

Focus group participants were recruited through a combination of methods, depending on participant type and site. To identify potential beneficiary participants, we relied on helpful local contacts, reverse-directory resources to target residents of low-income housing complexes, and lists of names and addresses provided by CMS. MPR identified geographic areas that seemed to have sufficient beneficiary samples and were small enough to accommodate the travel considerations of elderly and disabled beneficiaries. For the most part we used a grassroots approach to recruit information intermediaries,²² who were identified through a combination of suggestions from local Access to Benefits Coalitions and by networking with members of the case study site's local senior and disabled support community (such as social service agencies, advocacy organizations, and faith-based groups). We attempted to rely on professional focus group facilities in the case study sites to recruit family caregivers, pharmacists, and nursing home administrators. However, in a couple of the sites, we had to use grassroots methods and Internet directory services such as Yahoo!Yellow Pages to augment the inadequate numbers that the professional facilities generated. For the focus groups of family caregivers, we also asked nursing home administrators for referrals.

In both study phases, we asked low-income beneficiaries about their awareness of Part D and the LIS, how they learned about the programs, what sources and forms of information and assistance were most useful to them, and what they would recommend to improve the outreach and enrollment process. We asked other focus group participants, referred to in this study collectively as "information intermediaries," about their awareness and sources of knowledge of Part D and the LIS, how they helped educate and enroll beneficiaries, and their opinion of practices that worked well. In Phase II, we also asked intermediaries how their activities had changed from the previous year and why.

²² "Information intermediaries" refers to both formal intermediaries (including SHIPs, Area Agencies on Aging [AAAs], and local SSA offices) and informal intermediaries (including people who serve low-income Medicare beneficiaries through their work at senior centers, advocacy groups, volunteer organizations, senior housing complexes, ethnic membership organizations, and other such community-based organizations).

E. STUDY LIMITATIONS

Study Limitations of Qualitative Data for Identifying Best Practices. The data we collected are subject to limitations inherent in qualitative research methods. The most important is that the scope of each method is limited due to the in-depth, comprehensive data-gathering approaches required. In turn, this means that observation is limited to descriptions of what happens in small groups of people, which restricts our ability to generalize the results. For example, focus groups tended to be comprised of small groups—six to eight individuals. A second limitation is the very subjectivity of the inquiry, which leads to difficulties in establishing the reliability and validity of the approaches and information. Third, the focus group, case study, and expert/stakeholder interview respondents were not drawn from a random sample of potential respondents or promising practices, and therefore may not be truly representative of activities and experiences in the field. Instead, respondent selection was based on convenience samples, recommendations from a wide variety of knowledgeable experts and stakeholders intimately involved in Part D research or field operations, and CBOs themselves. For example, our convenience sample of low-income Medicare beneficiaries for the focus groups likely included participants who are more mobile and less socially isolated, on average, than other beneficiaries. As well, our discussions were conducted in English and therefore excluded non-English speakers. Thus, the focus group components of our study can provide insights into the kinds of beneficiary experiences that arise, but do not necessarily reflect how common or generalizable those experiences might be.

Additionally, as noted in Chapter I of the report, although respondents from all four of our data collection activities candidly shared their opinions about practices that seemed to work well—or not so well—during the first and second years of the Part D and LIS programs, none could substantiate their observations with firm evidence of success or failure. “Best practices” described in this report reflect respondents’ observations about actual practices that are working well, but these practices were not evaluated by either the respondents or MPR.

Despite these limitations, several aspects of the study strengthen the validity of our findings. The first is that we used four different research approaches to data collection that allowed our research questions to be examined from various angles in order to find corroborating or contradictory information about best practices. From our multiple data collection sources, we found strong convergence of data regarding overarching principles and best practice activities. In addition, our study involved multiple senior and junior researchers experienced with both qualitative research methods and with studying issues of public program enrollment among low-income populations. The building-block principles and key best practices described in this report were based on consensus among the researchers, derived from their individual research activities for the study and their review of findings from other research activities conducted for the study.

Limitations and Lessons Learned for Collection of Effectiveness and Cost-Effectiveness Data. Through a contract with NCOA, MPR attempted to collect comparative quantitative cost-effectiveness information on LIS outreach and assistance from our six case study sites to supplement best practices findings. Specifically, NCOA endeavored to estimate the per application costs of submitting LIS applications for potentially eligible beneficiaries. Empirical evidence that one practice is more effective than another—and especially that it is more cost-effective—is an important consideration for decisions about replicating, expanding, and funding practices that qualitative data can only suggest are best practices.

However, due to the sizeable challenges involved in NCOA's efforts to measure effectiveness and explore costs (for example, substantial differences in coalition structures, formal partnerships, and supporting infrastructure across the sites; and collection of retrospective data), we were ultimately unable to make robust cost-effectiveness comparisons across coalitions or sites. The effort itself, though, produced lessons about collecting cost-effectiveness information that may be useful to future similar endeavors. The major obstacles NCOA faced in collecting accurate data, as well as lessons learned, are described below.

1. The Multifaceted Efforts Carried Out by a Large Number of Federal, State, and Local Partners and the Complexity of Coalition Organizational Structures Made Comparable Data Collection Across Sites Extremely Challenging.

The most serious limitation inherent in the analysis was that it could not be used to compare accurately the cost-effectiveness of LIS-related activities *across coalitions, sites, or best practices*. The primary reason that the cost-effectiveness data were not comparable across the sites derives from the sizeable differences in coalition structures and formal partnerships. Although MPR knew when we proposed this analysis that we would collect cost data only from the organization(s) leading Part D and LIS efforts in each site, the consequences of not collecting data from all members of all of the coalitions we studied were much more limiting than anticipated. Only after we had conducted on-site case studies did we understand the extent to which many submissions of LIS applications are the result of multifaceted efforts carried out by a variety of federal, state, and local partners, rather than by one or two organizations acting individually. Five of the six case studies MPR conducted in 2007 featured complex coalitions (the sixth focused on a looser collaborative model), and they varied greatly in size, structure, and delegation of tasks.

An instructive example of the complexity of data collection was the difference in the number of coalition members involved in direct LIS application assistance across the sites, which depended in large part on the coalition's strategy for this activity. Two of the sites centralized LIS application assistance through a call center and/or on-site enrollment events organized and operated by a single organization (Atlanta and Cleveland), while another site (Chicago) devolved direct LIS application assistance to numerous community-based organizations through subcontracting relationships. The five AAAs in Maine used a mix of these strategies that depended on the characteristics of the region. In the former cases, capturing costs for most LIS applications completed by the site was relatively straightforward, but this was not a simple task in the latter, decentralized cases. Unfortunately, collecting data from a small number of key organizations whose efforts yield the most LIS application submissions reduces the coalitions to their parts, and because data were not available from a complete set of parts, this defeated the ability to compare per application costs reliably across coalitions.

Finally, coalitions differed substantially in the amount of assistance and support they received from other organizations, such as from their state SHIP or AAA offices, or regional SSA and CMS offices, and the cost of (or savings from) this assistance was not captured in the analysis due to the study's budget limitations. An example is the assistance that Atlanta GeorgiaCares received from its state SHIP office, which publicized its statewide 1-800 help-line number through media campaigns, outreach events, and statewide partnerships with physician

and pharmacist associations. As another example, the case study coalitions in both Maine and Chicago were heavily involved with larger Part D coalitions (the Maine Medicare Workgroup and the Make Medicare Work coalitions, respectively) that clearly contributed to the case study coalition's successes but were not captured in NCOA's cost data, again due to the study's budget limitations.

2. Organizations Found It Difficult to Report Retrospectively the Data Needed to Assess Costs Accurately.

Another key limitation of the NCOA data collection effort is that it was difficult for case study site organizations to estimate *retrospectively* the per application costs of LIS-related activities with much accuracy. Despite willingness to cooperate with a CMS study on an important topic, many private nonprofit organizations simply did not have the time or other resources to spare for extracurricular research. Many funders, including CMS, generally do not include significant data collection and evaluation dollars into grants or funding contracts for public benefits assistance activities, and organizations themselves do not have the resources to dedicate a full-time person to data collection and analysis. This limitation seemed to result in some organizations reporting incomplete data. For example, judging from what MPR learned during site visits about the number of staff significantly involved in LIS activities, at least one organization does not appear to have reported cost data for all its staff members heavily involved these activities.

3. Organizations Found It Difficult to Separate LIS-Related Costs from the Costs of Other Services Regularly Provided to Medicare Beneficiaries or Other Targeted Populations.

An important impediment to assessing per application costs of LIS-related activities also has to do with the nature of the activities and the way organizations perform them. AAAs, for example, often help beneficiaries apply for the LIS during comprehensive benefits checkups, which they promote as part of their usual service package; SHIPs offer a wide range of Medicare counseling and information services to beneficiaries that include claims assistance, clarification of Medicare Explanation of Benefits statements, and information on supplementary insurance, coordinated care plans, and long-term care options. Disability-related organizations provide services that include information and referral, advocacy, and help with independent living skills. Isolating the proportion of time and money spent on outreach and assistance with the LIS benefit versus other public benefits or services for low-income and non-low-income beneficiaries was very difficult and frequently resulted in "best guesses" of varying accuracy.

4. Lessons Learned

Accurately assessing the costs associated with LIS submissions, LIS approvals, or Part D plan choice in the future would require specifying data collection needs in advance of the data collection efforts and holding organizations accountable for data reporting through funding arrangements. Such a rigorous assessment of cost-effectiveness would not be an easy task to accomplish and would require targeted and likely significant resources, depending on the scope of activities for which data would be collected. For example, a cost-effectiveness study designed

to focus on factors that make a call center more or less effective or costly per completed LIS application would tend to be less expensive than a study designed to focus on the comparative costs of one coalition's implementation of its general LIS strategy and range of activities with another coalition's efforts. Even the former study would require significant resources to tease out the relative cost and effectiveness of individual factors that make a call center a best practice, given the number of factors that contribute to effectiveness and cost-effectiveness.²³

Significant pre-study design efforts are needed for any cost-effectiveness analysis. These would include, at a minimum, identifying which organizations among a coalition should submit both cost and outcome data to render the data comparable across coalitions; detailed information about the types of costs and outcomes data that should be submitted for a given activity or stage of activity; and clear definitions for each cost category, each outcome category, and each activity or stage of activity for which costs are to be collected.

²³ Factors might include, for example, prior call center experience of operators, operator training, quality assurance activities, advertisement costs, hours of operation, geographic reach of call center, propensity of a call center's target population to prefer telephone versus in-person assistance, average difficulty of cases fielded by the call center, wages for call center staff, use of a paid language line to help non-English-speakers, and cost of follow-up or return calls.