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**REPORT TO CONGRESS
BEST PRACTICES FOR ENROLLING LOW-INCOME BENEFICIARIES
INTO THE MEDICARE PRESCRIPTION DRUG BENEFIT PROGRAM**

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EXECUTIVE SUMMARY

Contained in the Conference Report accompanying Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), Congress asked that "...the Secretary shall report on best practices in the successful enrollment of low-income beneficiaries" into the Medicare prescription drug benefit program (Part D). The Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research, Inc. (MPR) to study which particular activities (outreach, partnerships, involvement of key organizations, or others) and at what level (federal, state, local) contribute to effectively enrolling and transitioning full-benefit dual eligible individuals, including the disabled and nursing home population, beneficiaries in the Medicare Savings Program, State Pharmaceutical Assistance Program (SPAP) participants, and other low-income beneficiaries into Part D and the Low-Income Subsidy (LIS) program. The study was conducted in two phases. Phase 1 was designed to examine the activities during the initial enrollment period (from late 2005 through mid-2006) and identify promising practices. Phase 2 was designed to examine changes in organizational outreach and enrollment strategies and activities between the first and second years of the programs and the reasons for those changes. Phase 2 also focused on the factors that make activities "best practices" and the factors that make these activities more replicable across different geographic areas and beneficiary subgroups. This report presents the findings from the study requested by Congress in the Conference Report.

The findings are drawn primarily from four data sources: (1) two rounds of telephone interviews with 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 communities; (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 with respect to their Part D and LIS activities; (3) two sets of focus groups with beneficiaries, health care providers and family caregivers, "information intermediaries"¹ who assisted beneficiaries with Part D and LIS applications and Part D plan choice, and (4) a case study of identified promising practices in six sites across the U.S.

"Best practices" in this report are activities, practices, or processes that led to outreach to and identification, education, and enrollment of low-income individuals into Part D and LIS, and that appeared to use the most appropriate strategies for a given population and setting. Although respondents from the data collection activities candidly shared their opinions about activities that seemed to work well—or not so well—during the first and second years of Part D and LIS, none could substantiate his or her observations with quantitative evidence of success or failure. Therefore, the best practices described in this report reflect respondents' observations about practices that seem to be succeeding in the field; however, neither the respondents nor MPR were able to evaluate the practices quantitatively in terms of effectiveness or cost-effectiveness.

¹ "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).

Key Findings

Participants in the various qualitative data collection 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 the LIS. In the absence of such lists, use local safety net provider lists of patients and lists of recipients of other low-income public benefit programs.
- Identify and educate beneficiaries by reaching out to them through their daily activities. Sending outreach workers to sites and neighborhoods where low-income individuals typically congregate (for example, low-income housing complexes) often proved more productive than at, for example, senior centers which do not necessarily serve low-income individuals.

- **Outreach and Education**

- Tailor advertisements and messages to local markets and local media. Messages should be customized to reflect the characteristics and preferences of the local community. Beneficiaries have greater trust in information delivered by local media (community or special-language newspapers, AM radio stations, and community-access cable television).
- Time community outreach to coincide with activities already planned for seniors, people with disabilities, and low-income persons in general. This might include, for example, conducting outreach at health fairs already organized by local senior centers.

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

- Provide comprehensive personalized one-on-one assistance. An example of comprehensive assistance may consist of trained counselors who help beneficiaries complete a LIS application and submit it to the Social Security Administration (SSA) for them. An example of personalized assistance may require a counselor to modulate his or her voice for a beneficiary with a hearing impairment.
- Provide assistance through counselors that beneficiaries trust, such as local community-based association (CBO²) staff. Applying for assistance means

² The term CBO in this report refers to information 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.

- divulging personal information about income, assets, and prescription drug needs. Beneficiaries are more comfortable disclosing financial and medical information to counselors they know or with whom they share a common trait.
- Provide assistance in the beneficiary’s primary language. 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.

The study revealed that three fundamental elements improve the chances for any of the identified best practices 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.** An oft-repeated refrain from individuals and organizations participating in the study 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 generally succeed in arranging and performing outreach and enrollment activities *that are visible to or directly involve beneficiaries*.
2. **Establishment of a comprehensive infrastructure of broader-based organizations with a national focus (for example, CMS and 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.** 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. The important building blocks of infrastructure include: development of outreach and application assistance strategy, development of high-quality lists of potential LIS-eligible individuals, provision of varying levels of program training and appropriate technological infrastructure, organization of flow of information top-down and bottom-up, and development of simplified, targeted, culturally appropriate materials and messages.
3. **Formation of inclusive and cohesive formal and informal partnerships to create the necessary links among CBOs and between CBOs and broader-based organizations.** Partnerships in many forms and across many types of organizations are helpful for increasing Part D and LIS enrollment and promoting informed Part D plan choice among low-income beneficiaries. Partnerships that produce added value for each partner organization can help foster continuing commitment to the partnership’s work.

The case study confirmed that the core set of best practices *may* be replicated in any community in the United States. However, it also clearly underscored that the details on *how* such practices

can be most effectively implemented are highly dependent on community characteristics and other contextual factors. Best practices work when they are appropriate for the intended audience, the geographic environment, the social service systems, and the relevant enabling infrastructure.

I. INTRODUCTION

Contained in the Conference Report accompanying the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), Congress asked that "...the Secretary shall report on best practices in the successful enrollment of low-income beneficiaries" into the Medicare prescription drug benefit program (Part D). CMS contracted with Mathematica Policy Research, Inc. (MPR) to study which particular activities (outreach, partnerships, involvement of key organizations, or others) and at what level (federal, state, local) contribute to effectively enrolling and transitioning full-benefit dual eligible individuals, including the disabled and nursing home population, beneficiaries in the Medicare Savings Program, State Pharmaceutical Assistance Program (SPAP) participants, and other low-income beneficiaries into Part D. The study was conducted in two phases. Phase 1 was designed to examine the activities during the initial enrollment period (from late 2005 through mid-2006) and identify promising practices. Phase 2 was designed to examine changes in organizational outreach and enrollment strategies and activities between the first and second years of the programs and the reasons for those changes. Phase 2 also focused on the factors that make activities "best practices" and the factors that make these activities more replicable across different geographic areas and beneficiary subgroups.

Background

Low-income beneficiaries can receive full or partial subsidies of premiums¹ and reductions in cost-sharing² for the Medicare prescription drug benefit through the low income subsidy (LIS) program. Qualifications for the low-income subsidy and amounts in cost-sharing vary based on the income level and assets of the beneficiary. Certain groups of low-income Medicare beneficiaries automatically qualify (deemed) for the LIS program. These include the full-benefit dual eligible individuals (Medicare beneficiaries who also have full Medicaid benefits), Medicare beneficiaries who are recipients of Supplemental Security Income benefits and participants in the Medicare Savings Programs (MSP)(Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, and Qualifying Individuals). Beneficiaries with low incomes and limited resources who do not fall into one of the automatic subsidy eligibility groups (LIS applicants) can apply either through the Social Security Administration (SSA) or the State Medicaid office.

¹ Beneficiaries eligible for the full subsidy received 100% premium subsidy. For beneficiaries eligible for the partial subsidy, the law sets the sliding scale premium percentage (100%-25%) based on the income and poverty level for household size.

² Cost sharing refers to the beneficiary's expenses (deductible and copayment or coinsurance) in the Part D plan, with the exception of the premium. Beneficiaries eligible for the full premium subsidy have no deductible or copayment amounts. For beneficiaries eligible for the partial subsidy, the deductible in 2008 is \$56 and the coinsurance remains at 15%. Copayment is a fixed dollar amount (\$2.25 for generic or preferred multiple source/\$5.60 for other drugs in 2008) and coinsurance is a percentage. Copayment and coinsurance are mutually exclusive; a beneficiary would not be responsible for paying a copayment and coinsurance at the same time.

Consistent with requirements of the MMA, full-benefit dual eligibles were also automatically enrolled into a Part D plan by CMS in advance of the implementation of Part D in 2006. However, these beneficiaries were able to switch to a different plan than the one in which they were auto-enrolled. If they took no action, their enrollment into the CMS-selected plan became effective January 1, 2006. Full-benefit dual eligible beneficiaries also were allowed a Special Enrollment Period (SEP) that allows them to switch plans at any time. Other low-income beneficiaries, whether they were deemed into or applied and were approved for the LIS, were given until March 2006 to choose a plan on their own. Otherwise, CMS “facilitated” their enrollment into a CMS-selected plan effective May 2006. Once enrolled, beneficiaries had the opportunity to switch plans until the end of 2006.

Currently, CMS deems beneficiaries newly identified as automatically eligible for the LIS monthly based on information sent from States about Medicaid benefits and from SSA about SSI benefits. Beneficiaries are always deemed at least through the end of the calendar year³. In August of each year, CMS reviews all currently deemed individuals and determines if they qualify to be deemed for the following year. Between September and October of each year, CMS notifies beneficiaries who will not be deemed in the coming year or beneficiaries who continue to qualify but will have a change in their co-pay level.

For LIS applicants, SSA currently determines the beneficiary’s premium subsidy level and informs CMS via daily files. Approved LIS applicants who report a Subsidy Changing Event (SCE), such as changes in marital status, during the year will receive an immediate re-determination of subsidy eligibility. SCE events result in changes the month after the month of the report. Approved LIS applicants who experience an SCE can, therefore, have an increase, decrease, or termination of their subsidy at any point during the year. Any other reported changes (changes in income, resources, household composition) are flagged and addressed in the annual re-determination process each August if the other event is reported between January and August of the of the current year. If the other event is reported between August Re-determination selection and December, the other event is addressed immediately⁴. In September, SSA mails affected beneficiaries a form called “Social Security Administration Review of Your Eligibility for Extra Help” for the individuals to fill out and return to SSA. SSA processes these re-determinations and notifies the beneficiaries of any change in, no change in, or termination of their LIS eligibility status. Beneficiaries whose LIS benefits were terminated and request a timely appeal have the option to have their LIS benefits continue until a decision is made on the appeal. Any change in the subsidy level based on the annual re-determination takes effect January 1st of the next year.

³ Beneficiaries are deemed from the earliest month they are reported by their state or by SSA until at least the end of the calendar year. (SSA reports the SSI recipients. The states report the full Medicaid and the MSP recipients. If the state or SSA reports to CMS that a particular beneficiary is in a status for deeming between July and December, they will also be deemed for the next year in CMS’ re-determination of deemed status process.)

⁴ SSA also includes other individuals in the annual re-determination process, such as those due for an initial or cyclical re-determination or those with characteristics that require scrutiny (such as a case where spouses living together who file for the subsidy separately and who are awarded different levels of subsidy based on the information in their separate applications).

CMS automatically enrolls or facilitates enrollment of LIS beneficiaries into a Part D plan on an ongoing basis. All LIS recipients may change Part D plans on a monthly basis through a special enrollment period (SEP). This SEP allows individuals to enroll in, or disenroll from, a Part D plan.

CMS, in partnership with SSA and States, has mounted a multifaceted, cooperative effort over the past several years to minimize the challenges of identifying and enrolling low-income beneficiaries into Part D and the LIS program. CMS, along with its partners, continues to refine its strategy to reach and enroll low-income beneficiaries into Part D. Because of these efforts, as of January 2008, approximately 25.4 million beneficiaries were enrolled in Medicare Part D of which 9.4 million were LIS beneficiaries.

Overview of Report

This report presents the findings from the study requested by Congress in the Conference Report. After discussing the study methodology, the report briefly summarizes the types of outreach education, and enrollment activities that took place during the first two years of Part D and the LIS programs; what changes occurred between the first and second years of the programs and why; identified “best practices”; and what factors affect the ease of replicating, disseminating, sustaining and expanding these best practices. Appendix A contains a brief discussion on the study’s limitations.

II. DATA SOURCES & METHODS

The study was designed to capture the “early implementation” (Phase 1) and “experienced implementation” (Phase 2) activities and beneficiary experiences with regards to applying for the LIS and enrolling in Part D. The findings are drawn primarily from four data sources: (1) two rounds of telephone interviews with 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 communities; (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 with respect to their Part D and LIS activities; (3) two sets of focus groups with beneficiaries and family caregivers, “information intermediaries”⁵ who were assisting beneficiaries with Part D and LIS applications and Part D plan choice, and health care providers, and (4) a case study of identified promising practices in six sites across the U.S.

Each data source is described in more detail below:

Interviews With Experts And Stakeholders

Phase 1 semi-structured telephone interviews were conducted between late May and early July 2006 to acquire an understanding of the range of Part D outreach, education, and enrollment activities taking place at the national, state, and local levels. Respondents were asked 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. 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

⁵ “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).

- Independent experts involved in the study of Medicare, beneficiary education, and prescription drug benefits

Phase 2 semi-structured telephone interviews were conducted between March and April 2007, with representatives from the same groups listed above. These interviews focused on changes that had occurred over the previous year and practices that respondents reported were particularly effective, whether new or continuing. Mathematica Policy Research (MPR) asked respondents to place emphasis on practices that focused on, or seemed to be exceptionally effective in, getting individuals (not automatically eligible) to apply for the LIS.

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. The survey was sent to the 51 state Medicaid agencies, 51 SHIPs, and 24 SPAPs in the 50 states and the District of Columbia. 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.

A total of 84 completed surveys were submitted by state agencies. 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.

Focus Groups And Telephone Discussions

Phase 1 focus groups were conducted from late June to early October 2006 to gain perspective on respondents' experiences during the 2006 Part D open-enrollment period, which ended May 15, 2006. Nearly 30 focus groups and more than 40 telephone discussions were held with (1) community-dwelling beneficiaries who were deemed eligible for the LIS, LIS applicants and with family caregivers of nursing home residents, (2) representatives of local Area Agencies on Aging (AAA), SHIPS, SSA offices, and community organizations; and (3) pharmacists, physicians, and nursing home administrators. Focus groups were held in Columbia (South Carolina), Seattle, Indianapolis, and the Bronx. Some of the criteria used to select sites included sites with fairly high concentrations of low-income elders and racial and ethnic minority groups, sites in close proximity to rural areas in order to identify promising outreach and enrollment activities in such areas, and sites with a qualified SPAP to learn more about the interaction between SPAPs and Part D. Eliminated from consideration were any sites that had already been selected for any other CMS study of the Part D program.

Phase 2 focus groups were conducted between July and October 2007 and were designed to complement the case study of best practices (described below). MPR held 25 focus groups and 12 individual telephone discussions with groups similar in composition to those participating in Phase 1. 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 knowledge of the availability of senior services in the area. Focus group sites selected were in Albuquerque, New Mexico; Atlanta, Georgia; Augusta, Maine and Chicago, Illinois.

In both study phases, low-income beneficiaries were asked 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. Information intermediaries were asked 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 2, intermediaries were also asked about how their activities had changed from the previous year and why.

Case Study

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 processes that appeared promising for overcoming barriers to helping low-income Medicare beneficiaries apply for the LIS and carefully choose a Part D plan. Site visits for the case study were conducted in August 2007 in Maine, metropolitan Atlanta, greater Cleveland, the Chicago suburbs, southern New Mexico, and Idaho. 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. At these sites, MPR interviewed the following types of respondents:

1. Lead organization for the site
2. Key partner organizations, as identified by the lead organization
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 AAA directors, and CMS regional offices
4. District-level SSA offices

Most data were collected during three-day visits to each of the sites. MPR typically interviewed 10 to 12 respondents while on site, and attended enrollment-related activities. Most of the discussions with representatives of CMS and SSA by telephone were conducted before or soon after the site visit. Discussions focused on activities the site organizations performed between June 2006 and August 2007. This time frame was chosen 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, Part D enrollment period.

III. OUTREACH AND ENROLLMENT ACTIVITIES THAT TOOK PLACE DURING THE FIRST TWO YEARS OF PART D AND LIS

Many organizations geared up to help all types of beneficiaries to process and consider complex information relating to the LIS and Part D. MPR's survey of state agencies, interviews with experts involved in Part D and LIS outreach, education and enrollment, and review of existing public literature were the primary sources for understanding the strategies and practices pursued by these organizations—particularly those related to helping low-income beneficiary groups.

The national, state, and local organizations that participated in the 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. The establishment or solidification of different types of partnerships at varying levels (national, state, local), either between organizations or through coalitions, were also common activities. Table III.1 at the end of this section provides examples of the types of activities conducted during the first two years of Part D.

Representatives of many organizations interviewed for this study 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.

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"> • Used state and SSA data on Medicaid and SSI-eligible beneficiaries to deem these individuals eligible for LIS • Maintained the database of beneficiaries eligible for Part D and LIS • 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 U.S. Administration on Aging (AoA), provided additional funding to National Association of Area Agencies on Aging (n4a) and National Association on State Units on Aging (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 AoA and the National Council on Aging (NCOA) • Developed on-line Medicare Prescription Drug Plan Finder • Created a website with Part D information for pharmacists

Organization	Examples of Activities
Social Security Administration (SSA)	<ul style="list-style-type: none"> • Submitted SSI data to CMS for the LIS deeming process • Determined eligibility for LIS applicants • Developed on-line LIS application • Mailed LIS applications to nearly 19 million potential LIS-eligibles and conducted follow-up • 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 • Trained 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: EXAMPLES OF PART D/LIS ACTIVITIES BY ORGANIZATION TYPE (cont.)

Organization	Examples of Activities
State Agencies (Medicaid, SPAPs)	<ul style="list-style-type: none"> • Submitted data on Medicaid eligibles to CMS for the LIS deeming process • 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 www.medicarerxoutreach.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)

Table III.1: EXAMPLES OF PART D/LIS ACTIVITIES BY ORGANIZATION TYPE (cont.)

Organization	Examples of Activities
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
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

IV. CHANGES IN OUTREACH AND ENROLLMENT ACTIVITIES 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, Phase 2 focus groups with intermediaries, expert/stakeholder interviews, and the summer 2007 case study investigated whether strategies or activities for assisting beneficiaries changed after the first Part D enrollment period and, if so, why. 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, there were reports of some significant changes, as described below.

Some Increased Focus On Low-Income Populations

About half of informal intermediary and health provider focus group participants, stakeholder respondents, and case study interviewees said they began to focus specifically on the LIS population 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. The demand was mainly from new Medicare beneficiaries, beneficiaries who were reassigned⁶ 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.

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 could provide the needed information and assistance.

⁶ Beneficiaries were re-assigned to a new Part D plan when their previous plan terminated or increased its premium beyond that covered by the LIS.

Emphasis On Comprehensive Benefits

Second-year activities were affected by what intermediary respondents often termed “mission fatigue” brought on by a very busy first year of providing Part D and LIS training and assistance. To address beneficiary and intermediary waning attention to Part D and LIS messages, 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 National Council On Aging (NCOA), which screens for LIS eligibility while checking eligibility for other public benefits such as the Medicare Savings Programs, food stamps, or transportation vouchers.

Greater Use Of On-line Application Tools

Information 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 on-line applications more quickly (by several weeks) than paper applications, because all questions must be answered to submit an on-line application, the information intermediaries switched from helping beneficiaries file paper LIS applications to helping them file on-line applications. In addition, several information intermediaries commented that the CMS Plan Finder tool seemed more user-friendly in the second year than when first introduced⁷. However, none said that beneficiaries themselves were using the on-line tools with any greater frequency than before.

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 focus group participants, providing one-on-one application and enrollment assistance has, for the most part,

⁷ In the second year of the Part D program, CMS improved the Plan Finder tool to specifically target CBOs who may be assisting beneficiaries with plan enrollment.

become a low-volume, routine activity for CBOs that still offer it. Many nursing homes now screen entrants 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 access to Benefits Coalition (ABC).

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.*** 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.

- ***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.

Changes In Commitment To Outreach Effort

Information intermediaries said that by the second year CMS regional office staff demonstrated increased knowledge about Part D and LIS — an improvement noticed by information 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, information 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. 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 believed the future of ongoing funding from CMS for outreach and enrollment was uncertain, resulting in diminished commitment on the part of some to future outreach and enrollment efforts.

CMS Efforts Since The Completion Of These Interviews

The Phase 2 data collection activities were conducted from March through October 2007. Since these interviews, CMS has undertaken numerous activities (providing funding opportunities, conducting regional campaigns, and other activities with partners) that address the concerns of respondents regarding CBO funding and perceived decrease in the promotion of the Part D and the LIS programs. In the area of funding for LIS activities, CMS awarded the National Association of Area Agencies on Aging (n4A) contracts to conduct outreach and counseling activities in targeted LIS-eligible areas across the country starting in October 2007. The subcontractors have held over 700 outreach events and reached approximately 38,957 people through the second quarter of FY2008. These events provided one-on-one counseling to over 17,000 individuals.

In June 2008, CMS provided \$7.5 million in additional funding to SHIPS to assist in their efforts to find lower income beneficiaries and promote application submission. CMS also provided analyses that overlay zip code level targeting data with SHIP activity data that can assist SHIPs with identifying areas to concentrate on building outreach capacity.

The CMS regional outreach campaign targets counties across the country with the most densely populated numbers of individuals without drug coverage and who may qualify for the LIS. All CMS regional offices perform the following activities in support of this campaign including:

- Coordinating with regional SSA offices,
- Sharing LIS data and regional outreach plans with key partners,
- Promoting participation in a CMS-sponsored LIS Summit,
- Getting earned media support,

- Working with local partners in targeted areas where data shows high concentrations of beneficiaries potentially eligible for the LIS and to identify strategies to reach these beneficiaries, and
- Identifying new partners (provider and faith-based organizations) to assist in LIS outreach.

CMS is working with the Health Resources Services Administration and the National Association of Community Health Centers to identify opportunities to connect community health centers (CHCs) with SHIPs and AAAs who are engaged in LIS outreach and LIS application assistance. CHCs are located in many communities with a high density of low-income beneficiaries. Approximately 7 percent of the people served by CHCs are Medicare beneficiaries, but the other CHC clientele are also likely to have family members who are Medicare beneficiaries with limited incomes.

V. BEST PRACTICES FOR ENROLLING LOW-INCOME BENEFICIARIES IN PART D AND LIS

A. BEST PRACTICES

“Best practices” in this report are activities, practices, or processes that led to outreach to and identification, education, and enrollment of low-income individuals into Part D and LIS, and that appeared to use the most appropriate strategies for a given population and setting. Although respondents from the data collection activities candidly shared their opinions about activities that seemed to work well—or not so well—during the first and second years of Part D and LIS, none could substantiate his or her observations with quantitative evidence of success or failure. Therefore, the best practices described in this report reflect respondents’ observations about practices that seem to be succeeding in the field; however, neither the respondents nor MPR was able to evaluate the practices quantitatively in terms of effectiveness or cost-effectiveness.

Participants in Phase 2 focus groups, expert/stakeholder interviews, and case studies 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 the LIS; 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

These best practices are described in greater detail below.

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 information intermediaries as a problem. Partnerships with CBOs 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, CHCs, other 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, 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)¹ 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 to identifying potentially-eligible LIS recipients 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.

¹ A GIS is a computer system capable of capturing, storing, analyzing, and displaying geographically referenced information; that is, data identified according to location.

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 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, 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, information 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. One-on-one application and enrollment assistance was most useful to beneficiaries 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 on-line 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 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."

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 (on-line 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, for example, local CBO staff. 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. For example, none of the case study sites referred beneficiaries to CMS or SSA toll-free helplines (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, respondents frequently mentioned that beneficiaries respond best to messages and materials associated with organizations they trust. All the local SSA offices and SHIPs said that partnering with CBOs that had already earned the trust of low-income Medicare beneficiaries was an effective way to engage those beneficiaries.

The need for trusted messengers was particularly acute for some beneficiary subgroups. Most Hispanic beneficiaries, according to some respondents, are more likely to trust information they receive from CBOs than from government agencies. Thus, respondents from a national Hispanic

organization 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. There were 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

The study revealed that three fundamental elements improve the chances for any of the identified best practices 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 fundamental elements follow.

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

An oft-repeated refrain from individuals and organizations participating in the study 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.

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.
- ***CBOs Can Identify and Educate Beneficiaries by Reaching Them During Their Daily Activities.*** CBOs often have considerable familiarity with the places where potential 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.
- ***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 the 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.

- ***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.*** Respondents from local SSA offices and SHIPs 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.

CMS has successfully worked with CBOs through the N4A and SHIP grants described in the previous chapter. In addition, CMS has worked with CBOs through its regional offices. For example, the Philadelphia Regional Office (RO) developed a new partnership with Philabundance, a community-based organization to distribute approximately 4,000 food boxes to elderly residents in the Philadelphia area. Each box contained the photo novella and the SSA brochure explaining the LIS and Part D programs. The RO has also worked with the Food Bank of Delaware to speak and exhibit at their Hunger Awareness event in Wilmington as well as the placement of LIS information in 700 food baskets and in the mobile food pantry that travels across the state. Similar efforts are underway with the Virginia Food Bank to distribute materials to over 500 families.

The Atlanta RO established a partnership with the Atlanta Community Food Bank (Food Bank) that resulted in CMS involvement in their events and activities as well as the Food Bank utilizing LIS materials. The events have included other partners such as the Internal Revenue Service and AARP and are venues where individuals can receive tax assistance in filing for their Economic Stimulus refunds as well as assistance with applying for the LIS. The Food Bank is also investigating possible changes to their intake software to include the LIS program in their intake screening. If successful, other food banks nationwide would include LIS screening routinely in their intake processing.

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. The following describe the important building blocks of the infrastructure and identify the types of organizations best suited to each infrastructure component, according to 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

Federal Agencies: Inform regional offices and state and city agencies about changes in eligibility requirements and enrollment periods. Develop high-quality qualified lists of potential LIS eligibles. Develop on-line 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 national and state policy changes. Fund state and community activities. Develop informational materials and tools that can be tailored to local circumstances.

Organizations and Agencies Serving a State, a City, or a County Group: Set policy for SPAP and MSP eligibility (state organizations only). Develop overarching 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 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 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.

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 Strategy. This study found 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). Strategy also pertains to crafting and disseminating a message about LIS that reduces the perceived stigma described above. For example, communications directors in CMS regional offices can help local organizations devise a strategy for pursuing media coverage from regional sources. SHIPs can also help and design and implement state-wide and local media campaigns.

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 do not automatically qualify for the LIS, 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 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.

Provision of Varying Levels of Program Training. 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. They devoted significant resources to training as many staff in CBOs and local health providers (such as pharmacists and physicians) as funds allowed on the basis of Part D and LIS. An important role for SHIPs identified by study respondents was to provide training to CBOs, professionals and health care providers to facilitate cross-screening and cross-referrals. 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.

Training the people who design and implement outreach and enrollment activities was identified as 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.

Provision of Appropriate Technological Infrastructure. The on-line 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 on-line tools on their own, but organizations assisting beneficiaries used them daily.

The use of on-line 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, 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. 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. Respondents 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 languages². 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.

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

Partnerships in many forms and across many types of organizations are helpful for 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 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.

Partnerships should produce added value for each partner organization. This is important in order to foster continuing commitment to the partnership's work. 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 the case-study coalition leaders—AgeOptions—encouraged groups to join the Illinois Make Medicare Work coalition by offering funds, technical assistance and referrals,

² All CMS official publications are translated into Spanish; some other publications are translated into Chinese, Korean, and Vietnamese. For example, CMS' photo novella on the Low-Income Subsidy is available in English, Spanish, Chinese, Korean, and Vietnamese.

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.

New Types of Partnerships Formed for Part D. Respondents often stated that while partnership-building is always difficult, the advent of Part D made it somewhat easier. 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. 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. 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. 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.*** 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 in the study 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.

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

A. REPLICATING BEST PRACTICES

The 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.

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.

Geographic Environment. The size of the geographic area as well as its urban or rural character, affects whether a particular outreach strategy will work in one area compared to another. In the Atlanta area, for instance, 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.

Replicating 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.

The Social Services System. The structure of governmental agencies and the aging and disability services network in a local area help determine whether a particular strategy is transportable from one community to another. For example, 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 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 Maine Medicare Workgroup. 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 Maine Medicare Workgroup 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

Respondents often noted that 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 in the 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 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 ABCs made up of CBOs).

C. 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. 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 in the long term. 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 for one-on-one assistance.

To compound the reduced-funding issues, 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. These efforts may not be financially sustainable when enrollment levels off. However, existing telephone helplines, such as those operated by SHIPs and AAAs, could easily make LIS part of their customer service routine.

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
STUDY LIMITATIONS

STUDY LIMITATIONS OF QUALITATIVE DATA FOR IDENTIFYING BEST PRACTICES

The data 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 the 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, the 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. In addition, the discussions were conducted in English and therefore excluded non-English speakers. Thus, the focus group components of the 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, 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 the findings. The first is that four different research approaches to data collection were used that allowed the research questions to be examined from various angles in order to find corroborating or contradictory information about best practices. From the multiple data collection sources, there was strong convergence of data regarding overarching principles and best practice activities. In addition, the 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.