

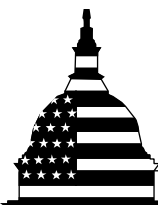
September 2012

MEDICARE SAVINGS PROGRAMS

Implementation of Requirements Aimed at Increasing Enrollment

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Why GAO Did This Study

Congress established four MSPs and the LIS program to help low-income beneficiaries pay for some or all of Medicare's cost-sharing requirements. Historically low enrollment in MSPs has been attributed to lack of awareness about the programs and cumbersome enrollment processes through state Medicaid programs. MIPPA included requirements for SSA and state Medicaid agencies aimed at eliminating barriers to MSP enrollment. Most notably, MIPPA created a new pathway to MSP enrollment by requiring SSA, beginning January 1, 2010, to transfer the information from a LIS application to the relevant state Medicaid agency, and the state must initiate an application for MSP enrollment. MIPPA also required GAO to study the effect of these requirements. This report describes (1) SSA's implementation of the requirements; (2) how MSP enrollment levels have changed from 2007 through 2011 and the factors that may have contributed to those changes; and (3) the effects of the MIPPA requirements on states' administration of MSPs.

GAO reviewed documents and data on SSA's efforts to transfer applications and implement other MIPPA requirements, analyzed MSP enrollment data from CMS, surveyed Medicaid officials from the 50 states and the District of Columbia, and contacted officials from 6 states selected, in part, because they accounted for over 20 percent of MSP enrollment.

MEDICARE SAVINGS PROGRAMS

Implementation of Requirements Aimed at Increasing Enrollment

What GAO Found

The Social Security Administration (SSA) took a number of steps to implement the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requirements aimed at eliminating barriers to Medicare Savings Program (MSP) enrollment and spent about \$12 million in fiscal years 2009 through 2011 to do so. SSA reported transferring over 1.9 million Low-Income Subsidy (LIS) program applications to state Medicaid agencies between January 4, 2010 and May 31, 2012. SSA also took steps to make information available to potentially eligible individuals, conduct outreach, and train SSA staff on MSPs. In fiscal years 2009 and 2010, SSA spent \$9.2 million of the \$24.1 million appropriated by MIPPA for initial implementation costs, and in fiscal year 2011, SSA spent about \$2.5 million of the \$3 million appropriated by MIPPA for ongoing administrative costs. SSA officials told GAO that implementing the MIPPA requirements has not significantly affected its overall workload and that SSA expects funding provided under the law to be sufficient to carry out the requirements.

Using data from the Centers for Medicare & Medicaid Services (CMS), GAO estimates that MSP enrollment increased each year from 2007 through 2011. The largest increases occurred in 2010 and 2011 (5.2 percent and 5.1 percent respectively), the first 2 years that the MIPPA requirements were in effect. Several factors may have contributed to the higher levels of growth in MSP enrollment during these 2 years, including SSA application transfers and outreach, other MIPPA provisions related to MSPs, and the economic downturn. For example, while there are no nationwide data demonstrating the effects of the SSA application transfers, officials from 28 states reported that MSP enrollment had increased as a result of the transfers.

Officials from most of the six states GAO contacted to supplement its survey reported that the SSA application transfers led to changes in eligibility systems and had increased the state's workload, that is, the time spent processing MSP applications. The extent to which the application transfers resulted in system or workload changes may have depended on whether states accepted SSA's verification of the information transferred, as allowed under CMS policy. In response to GAO's survey, officials from 35 states reported that the state required the applicant to reverify at least some of the information. GAO found from interviews with officials from selected states that requiring reverification from applicants included multiple steps by the state and applicant. In contrast, officials from two states that accepted SSA's verification of the information told GAO that the state was able to enroll some of the applicants transferred by SSA with little to no work required by caseworkers. Differences in how SSA and states count income and assets when determining eligibility for LIS versus MSPs may have driven states' decisions to require verification from applicants. States have the flexibility under federal law to align methods for counting income and assets for MSPs with those for LIS and doing so may reduce the administrative burden of processing the transferred applications. However, doing so would likely increase enrollment and, therefore, increase state Medicaid costs.

SSA, in an e-mail, agreed with GAO's description of its implementation of MIPPA requirements.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
FPL	federal poverty level
FTE	full time equivalent
LIS	Low-Income Subsidy
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MSP	Medicare Savings Program
NCOA	National Council on Aging
QDWI	Qualified Disabled and Working Individual
QI	Qualifying Individual
QMB	Qualified Medicare Beneficiary
SLMB	Specified Low-Income Medicare Beneficiary
SSA	Social Security Administration
SSI	Supplemental Security Income

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September 14, 2012

Congressional Committees

Medicare, which is administered by the Centers for Medicare & Medicaid Services (CMS), provided health insurance coverage for a broad array of services, including hospital, physician, home health, and other services, to almost 49 million Americans in 2011 who were elderly, disabled, or had end-stage renal disease.¹ Medicare beneficiaries pay a portion of the program's costs through cost-sharing provisions—including premiums, deductibles, and coinsurance—that can be difficult to afford for low-income beneficiaries.² In 2010, an estimated one third of all Medicare beneficiaries had annual incomes that were less than 150 percent of the federal poverty level (FPL),³ which in 2012 means an annual income below \$16,755 for a single person. Between 1989 and 1998, to assist low-income beneficiaries, Congress established four Medicare Savings Programs (MSP)—the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled and Working Individual (QDWI) programs.⁴ MSPs help pay for some or all of Medicare beneficiaries' cost-sharing requirements, each with differing income eligibility requirements and levels of benefits. Under MSPs, state Medicaid programs—under the oversight of CMS—pay Medicare beneficiaries' premiums and, for some beneficiaries,

¹Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare Parts A and B are known as Medicare fee-for-service. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional, and covers hospital outpatient, physician, and other services. Medicare beneficiaries have the option of obtaining coverage for Medicare services from private health plans that participate in Medicare Advantage—Medicare's managed care program—also known as Part C. All Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Part D, either as a stand-alone benefit or as part of a Medicare Advantage plan.

²Throughout this report, we use the term “beneficiary” to refer to a Medicare beneficiary.

³See “Distribution of Medicare Beneficiaries by Federal Poverty Level, states (2009-2010), U.S. (2010)” (The Kaiser Family Foundation), accessed Apr. 25, 2012, <http://www.statehealthfacts.org>.

⁴The QMB program was established in 1989, followed by the QDWI program in 1990, the SLMB program in 1993 and the QI program in 1998.

deductibles, copayments and coinsurance.⁵ In 2003, Congress created the Low-Income Subsidy (LIS) program, which is a separate program administered by the Social Security Administration (SSA) and states to assist low-income Medicare beneficiaries with the costs of outpatient prescription drug coverage under Medicare Part D.⁶

While federal law generally requires state Medicaid programs to provide MSP benefits to individuals who apply and meet federal eligibility requirements, there are financial incentives for states to enroll some beneficiaries and disincentives to enrolling others. Enrolling beneficiaries in an MSP can reduce state Medicaid spending for certain beneficiaries. For example, for beneficiaries eligible for full Medicaid benefits, paying beneficiaries' Medicare premiums ensures that Medicare is the primary payer for certain services rather than the state Medicaid program. For beneficiaries who are only eligible for Medicaid coverage of Medicare cost sharing and no other Medicaid benefits, there is no immediate financial incentive for the state to enroll the beneficiary in MSPs. In these cases, providing MSP benefits generally increases the costs of the state Medicaid program.⁷

Historically, MSPs have had low enrollment rates. For example, in 2004, the Congressional Budget Office estimated that only 33 percent of eligible beneficiaries were enrolled for QMB benefits and only 13 percent were

⁵Medicaid is a joint federal-state program that finances health care for certain low-income populations. Under state Medicaid programs, QMB, SLMB, and QDWI are financed jointly by states and the federal government. QI is financed entirely by the federal government as long as costs fall within a state's annual allotment for the program. The Kaiser Commission on Medicaid and the Uninsured reported that Medicaid paid \$32.1 billion in federal fiscal year 2008 for Medicare premiums and cost-sharing for Medicare services. See Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role for Dual Eligible Beneficiaries* (Washington, D.C.: April 2012).

⁶GAO issued a report and two testimonies in 2007 and 2008 on SSA implementation of LIS. See GAO, *Medicare Part D Low-Income Subsidy: Additional Efforts Would Help Social Security Improve Outreach and Measure Program Effects*, [GAO-07-555](#) (Washington, D.C.: May 31, 2007); *Medicare Part D Low-Income Subsidy: Progress Made in Approving Applications, but Ability to Identify Remaining Individuals Is Limited*, [GAO-07-858T](#) (Washington, D.C.: May 8, 2007); and *Medicare Part D Low-Income Subsidy: SSA Continues to Approve Applicants, but Millions of Individuals Have Not Yet Applied*, [GAO-08-812T](#) (Washington, D.C.: May 22, 2008).

⁷The exception to this is that those enrolled in the QI program, which is financed entirely with federal funds, do not increase the costs of state Medicaid programs.

enrolled for SLMB benefits.⁸ Other researchers have found that beneficiaries' lack of awareness and a cumbersome eligibility determination and enrollment process are the main barriers to enrollment. Congress has taken a number of steps to increase enrollment rates. For example, in 2000, Congress passed the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act, which included provisions requiring SSA to notify low-income Medicare beneficiaries that they may be eligible for MSP benefits.⁹ More recently, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) included new requirements for SSA and state Medicaid agencies aimed at eliminating barriers to MSP enrollment.¹⁰ Most notably, MIPPA created a new pathway to MSP enrollment by requiring SSA, beginning January 1, 2010, to transfer the information from an LIS application to the relevant state Medicaid agency and requiring the state Medicaid agency to use that information to initiate an application for MSP enrollment.¹¹ MIPPA also required SSA to make information on MSPs available to potentially eligible individuals, coordinate LIS and MSP outreach, and train personnel in explaining MSPs. MIPPA appropriated \$24.1 million to SSA for initial implementation of these requirements and up to \$3 million per year—to be provided by CMS to SSA under a funding agreement—beginning in fiscal year 2011 for the ongoing administrative costs of meeting these requirements.¹²

⁸The estimates completed by the Congressional Budget Office in 2004 are the most recent estimates available.

⁹Pub. L. No. 106-554, App. F, § 911(a), 114 Stat. 2763, 2763A-583 (adding section 1144 to the Social Security Act (SSA); codified at 42 U.S.C. § 1320b-14(b) (2010)). GAO issued a report in 2004 describing SSA's efforts to meet those requirements. See GAO, *Medicare Savings Programs: Results of Social Security Administration's 2002 Outreach to Low-Income Beneficiaries*, [GAO-04-363](#) (Washington, D.C.: Mar. 26, 2004).

¹⁰Pub. L. No. 110-275, § 113, 122 Stat. 2494, 2503 (amending sections 1144 and 1935(a) of the SSA; codified at 42 U.S.C. §§ 1320b-14, 1396u-5(a) (2010)) (hereafter, "MIPPA").

¹¹Throughout this report, we describe these exchanges of information between SSA and states as application transfers, as SSA is transferring all of the information from the LIS application.

¹²MIPPA required that SSA and CMS execute an agreement by which CMS would provide SSA the full administrative cost of SSA's MSP-related activities, starting in fiscal year 2011, and appropriated not more than \$3 million for each fiscal year for that purpose.

MIPPA also directed GAO to report on the effects of the MIPPA requirements on participation in MSPs and on SSA and states.¹³ In this report, we describe (1) SSA's implementation of the requirements aimed at eliminating barriers to MSP enrollment; (2) how MSP enrollment has changed from 2007 through 2011 and what factors may have contributed to those changes; and (3) any effects the requirements have had on states' administration of MSPs.

To describe SSA's implementation of the MIPPA requirements aimed at eliminating barriers to MSP enrollment, we reviewed documents and data on SSA's efforts to transfer applications to states to initiate MSP applications, make information available, coordinate outreach for LIS and MSPs, and train staff. We also reviewed documents on SSA spending of the \$24.1 million appropriation it received for initial costs associated with implementing these requirements and documents related to funding agreements between SSA and CMS for expenses related to administering these requirements in fiscal years 2011 and 2012; and we reviewed SSA data on how implementing the requirements affected workload. To supplement this review, we spoke with SSA officials about implementation of the requirements, including any challenges experienced.

To describe the change in MSP enrollment from 2007 through 2011, we used CMS data to estimate the annual change in enrollment. The data, reported by states to CMS, included state-level information on the number of Medicare beneficiaries for whom states will pay the Medicare Part B premium.¹⁴ In our estimates we used data from December of each year. The data do not reflect QDWI enrollment, which CMS officials estimated at less than 300 beneficiaries nationally as of March 2012. In addition, the data reflect some Medicare beneficiaries who are not eligible for the QMB, SLMB, or QI programs but for whom states finance the Part B premium. We were able to exclude some but not all of these beneficiaries

¹³MIPPA, § 113(a), 124 Stat. at 2505 (amending section 1144(c)(6) of the SSA; codified at 42 U.S.C. § 1320b-14(c)(6) (2010)).

¹⁴The data were derived from CMS's monthly Third-Party Buy-In file, which contains data from the CMS Enrollment Database. Data in the Enrollment Database are used by CMS to track enrollment and bill state Medicaid programs for the Part B premiums for individuals whose premiums the state has agreed to finance. States submit data regularly to CMS for updates to the Enrollment Database.

from our estimates.¹⁵ We took a number of steps to assess the reliability of CMS’s data, including interviewing CMS officials on the limitations of the data and reviewing the CMS policy manual outlining the requirements states must follow in reporting the data. We determined the data to be sufficiently reliable for the purposes of estimating the changes in MSP enrollment nationally over time; where relevant we stated the limitations of the data in the findings. (See app. I for more information on our analysis of the CMS data and our assessment of the data’s reliability.) To describe the factors that may have contributed to changes in MSP enrollment, we surveyed state Medicaid officials on the effects of the application transfers on MSP enrollment and received responses from all 50 states and the District of Columbia.¹⁶ To supplement our survey, we also contacted Medicaid officials from 6 selected states—Arizona, Colorado, Florida, Louisiana, Pennsylvania, and Texas—on the factors that may have contributed to changes in MSP enrollment and reviewed these states’ data on the outcomes of the application transfers where available. We selected these 6 states because together they accounted for over 20 percent of MSP enrollment in 2011, are geographically diverse, and vary in terms of their MSP eligibility requirements. In addition to the information collected from states, we reviewed SSA data on the outcomes of the application transfers. We also reviewed other MIPPA provisions that may have contributed to changes in enrollment.

To describe any effects of the requirements on states’ administration of MSPs, we asked officials from our six selected states about any changes the state made to information technology systems, business processes, or personnel—in particular, to receive and act upon the application transfers—and how the requirements have affected the state’s workload.

¹⁵States have the option to provide Medicaid benefits and payment for Medicare Part B premiums to beneficiaries that do not meet the eligibility requirements for MSPs but who otherwise qualify for Medicaid. For example, some states finance premiums for beneficiaries categorized as “medical assistance only” who are not eligible for MSPs. We excluded these beneficiaries from our estimates. Some states also finance premiums for beneficiaries categorized as “medically needy.” These beneficiaries may or may not meet the eligibility requirements for a MSP. We were not able to exclude these beneficiaries from our estimates, because CMS did not have data for this population for each year included in our analysis. For the same reason, we were not able to exclude beneficiaries for whom the state did not specify the eligibility category. While CMS did not have data for each year of our analysis for these populations, as of May 8, 2012, about 8 percent of beneficiaries were medically needy or did not have an eligibility category specified.

¹⁶In this report, we use the term “states” to refer to the 50 states and the District of Columbia.

We reviewed data from the selected states on the numbers of MSP applications received the year before transfer requirements took effect (2009) and in the first 2 years after the requirements took effect (2010 and 2011) when available. Finally, in our survey, we asked state Medicaid officials whether they required applicants to verify the information transferred by SSA, and we reviewed open-ended survey responses for any evidence of effects of the application transfers on state administration of MSPs.

We conducted this performance audit from February 2012 to September 2012 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicare covers almost 49 million beneficiaries. Individuals who are eligible for Medicare automatically receive Part A benefits, which help pay for inpatient hospital, skilled nursing facility, hospice, and certain home health services. A beneficiary generally pays no premium for this coverage unless the beneficiary or spouse has worked fewer than 40 quarters in his or her lifetime, but the beneficiary is responsible for required deductibles, coinsurance, and copayment amounts. Medicare-eligible beneficiaries may elect to purchase Part B, which helps pay for certain physician, outpatient hospital, laboratory, and other services. Beneficiaries must pay a premium for Part B coverage, which generally was \$99.90 per month in 2012.¹⁷ Beneficiaries are also responsible for Part B deductibles, coinsurance, and copayments. Beneficiaries electing to obtain coverage for Medicare services from private health plans under Part C are responsible for paying monthly Part B premiums and, depending on their chosen plan, may be responsible for a monthly premium to the Medicare plan, copayments, coinsurance, and deductibles. Finally, under Medicare Part D, beneficiaries may elect to

¹⁷Beneficiaries with higher incomes may pay a higher Part B premium, up to a maximum of \$319.70 for single beneficiaries with yearly incomes in 2010 above \$214,000 and for married beneficiary couples with yearly incomes in 2010 above \$428,000. The premium amounts are adjusted each year so that expected Medicare premium revenues equal 25 percent of expected Medicare Part B spending. 42 U.S.C. §1395r(a)(2000).

purchase coverage of outpatient prescription drugs from private companies. Beneficiaries who enroll in a Part D plan are responsible for a monthly premium, which varies by the individual plan selected, as well as copayments or coinsurance. Table 1 summarizes the benefits covered and cost-sharing requirements for Medicare Part A and Part B, referred to together as Medicare fee-for-service.

Table 1: Medicare Coverage and Beneficiary Cost Sharing for 2012 under the Medicare Fee-for-Service Program

Part A—Hospital insurance	Beneficiary pays^a
Part A premium	No premium if beneficiary or spouse worked at least 40 quarters in lifetime Up to \$451 monthly premium if beneficiary or spouse worked fewer than 40 quarters in lifetime
Inpatient hospital	\$1,156 deductible per benefit period ^b \$289 copayment per day for days 61-90 \$578 copayment per day for days 91-150 ^c All costs beyond 150 days
Skilled nursing facility ^d	Nothing for first 20 days per benefit period \$144.50 copayment per day for days 21-100 per benefit period All costs beyond 100 days per benefit period
Home health ^e	No cost sharing 20 percent coinsurance of Medicare-approved amount for durable medical equipment
Hospice ^f	No cost sharing Up to \$5 copayment per prescription for outpatient drugs for pain and symptom management 5 percent coinsurance of Medicare-approved amount for inpatient respite care
Blood	Cost of first 3 pints
Part B—Medical insurance^g	
Part B premium	\$99.90 per month ^h
Physician and medical	\$140 deductible each year 20 percent coinsurance for most services
Clinical laboratory	No cost sharing
Home health ^e	No cost sharing 20 percent coinsurance of Medicare-approved amount for durable medical equipment
Outpatient hospital	Coinsurance may vary by service
Blood	Cost of first 3 pints 20 percent coinsurance for additional pints

Source: GAO analysis of CMS documents.

^aThe information in this column reflects what beneficiaries enrolled in the Medicare fee-for-service program would pay. Beneficiaries enrolled in a Medicare Advantage Plan may pay either more or less depending on the costs of the plan.

^bA benefit period begins the day a beneficiary is admitted as an inpatient in a hospital and ends when the beneficiary has not received any inpatient hospital care for 60 days in a row. No deductible is charged for second and subsequent hospital admissions if they occur within 60 days of the beneficiary's most recent covered inpatient day.

^cAfter the first 90 days of inpatient care per benefit period, Medicare will help pay for an additional 60 days of inpatient care (days 91-150). Each beneficiary is entitled to a lifetime reserve of 60 days of inpatient coverage. Each reserve day may be used only once in a beneficiary's lifetime.

^dTo qualify, a Medicare beneficiary must require daily skilled nursing or rehabilitative therapy services, generally within 30 days of a hospital stay of at least 3 days in length, and must be admitted to the nursing home for a condition related to the hospitalization.

^eTo qualify for services, Medicare beneficiaries must be confined to their homes; have a plan of care signed by a physician; and need intermittent skilled nursing care (other than solely venipuncture for the purpose of obtaining a blood sample), physical therapy, speech-language services, or have a continuing need for occupational therapy services.

^fTo qualify for services, a Medicare beneficiary must be terminally ill and have 6 months or less to live.

^gNo cost sharing is required for certain preventive services, including specific screening tests for breast, colon, cervical, and prostate cancer, annual wellness visit, and flu and pneumonia vaccines.

^hMost beneficiaries pay the standard Part B premium amount of \$99.90 per month. Beneficiaries with higher incomes may pay a higher Part B premium, up to a maximum of \$319.70 for single beneficiaries with yearly incomes in 2010 above \$214,000 and for married beneficiary couples with yearly incomes in 2010 above \$428,000.

Many low-income Medicare beneficiaries receive assistance from Medicaid to pay Medicare's cost-sharing requirements. For Medicare beneficiaries qualifying for full Medicaid benefits, state Medicaid programs pay for Medicare's Part A (if applicable) and Part B premiums and cost-sharing requirements up to the Medicaid payment rate as well as for services that are not generally covered by Medicare.¹⁸ To qualify for full Medicaid benefits, beneficiaries must meet their state's eligibility criteria, which include income and asset requirements that vary by state.¹⁹ In most states, beneficiaries that qualify for Supplemental Security Income (SSI) automatically qualify for full Medicaid benefits.²⁰ Other beneficiaries may

¹⁸Within broad federal guidelines, states have considerable flexibility in how they administer their Medicaid programs. States administer covered services under a state Medicaid plan that CMS approves. State Medicaid programs must cover certain mandatory services, such as physician services and nursing facility care. (While Medicare covers some or all of up to 100 days of skilled nursing facility care following a hospitalization, Medicaid covers extended nursing facility care.) State Medicaid programs may also cover certain CMS-approved optional Medicaid services. The federal government shares the cost of state Medicaid expenditures according to a statutory formula, whereby the federal share ranged in 2012 from 50 to 74.2 percent of state Medicaid expenditures. States with lower per capita incomes receive higher Federal Medical Assistance Percentages. 42 U.S.C. §1396b(a) (2010).

¹⁹In this report, we use the term "assets" to mean an applicant's resources, such as funds in bank accounts and property other than one's home.

²⁰SSI provides cash assistance to aged, blind, and disabled individuals who have limited income and assets. In 2012, the income limit was \$698 per month, and the asset limit was \$2,000 for individuals and \$3,000 for couples. SSI asset limits typically exclude the beneficiary's automobile and house.

qualify for full Medicaid benefits through one of several eligibility categories that states have the option but are not required to cover, such as the medically needy category, which includes individuals with high medical costs.

Congress created several MSPs—QMB, SLMB, QI, and QDWI—and, more recently, the LIS program to further assist low-income Medicare beneficiaries with their premium and cost-sharing obligations. Each program has different benefits, and beneficiaries qualify for different levels of benefits depending on their income.²¹ (See table 2.)

Beneficiaries must also have limited assets to qualify for MSPs or LIS. MIPPA amended the asset limits for the QMB, SLMB, and QI programs to more closely align with the LIS limits beginning January 1, 2010.²² This raised the MSP asset limits for the first time since 1989 and ensured that those limits would be adjusted for inflation in the future.²³ As with other Medicaid benefits, states have the flexibility to extend eligibility for MSP benefits to a larger population than federal law requires to be covered by implementing less restrictive income and asset requirements, for example by eliminating asset limits or not counting certain types of income.²⁴ Therefore, eligibility requirements for MSPs vary across states, while requirements for LIS, which is administered by SSA, are uniform nationwide.

²¹All MSP enrollees are considered to be dually eligible for Medicare and Medicaid. However, for some, eligibility for Medicaid is limited to MSP benefits. Other enrollees, considered “full duals,” are eligible for full Medicaid benefits.

²²MIPPA, § 112, 122 Stat. at 2503 (amending section 1905(p)(1)(C) of the SSA; codified at 42 U.S.C. § 1396d(p)(1)(C) (2010)). The asset limit for QDWI was not changed by MIPPA.

²³In 2012, the asset limit for QMB, SLMB, QI and LIS was \$6,940 for an individual and \$10,410 for a couple.

²⁴Federal law provides states flexibility to use less restrictive or liberalized methodologies than are typically used for Medicaid in counting applicants’ income and assets to expand eligibility for MSPs. 42 U.S.C. § 1396a(r)(2)(2010); 42 C.F.R. § 435.601(b)(iii)(2011). Many states continue to use the methodology used for the Medicaid program, which generally follows the methodology SSA uses to count income and assets when assessing eligibility for SSI.

Table 2: Federal Income Limits and Benefits for Medicare Savings Programs and the Low-Income Subsidy Program

Program	Income limit as a percent of the federal poverty level	Medicare costs covered by the program
Medicare Savings Program (MSP)		
Qualified Medicare Beneficiary (QMB)	At or below 100%	Part A premium, deductible, copayments, and coinsurance, including for skilled nursing facility stays Part B premium, deductible, copayments, and coinsurance
Specified Low-Income Medicare Beneficiary (SLMB)	Above 100% but less than 120%	Part B premium
Qualifying Individual (QI)	At 120% but less than 135%	Part B premium
Qualified Disabled and Working Individual (QDWI)	Disabled and working Medicare beneficiaries whose incomes do not exceed 200%	Part A premium
Low-Income Subsidy (LIS) program		
Full subsidy	Below 135%	Drug plan premium, deductible, and coinsurance, and a portion of copayments
Partial subsidy	At 135% but less than 150%	Portion of drug plan premium, deductible, copayments, and coinsurance

Source: GAO analysis of CMS documents.

Note: Federal law provides states flexibility to use less restrictive or liberalized methodologies than are typically used for Medicaid in counting applicants' income and assets to expand eligibility for the MSPs.

MIPPA included several new requirements aimed at eliminating barriers to MSP enrollment. Specifically, MIPPA required SSA to, beginning January 1, 2010, transfer data from LIS applications, at the option of applicants, to state Medicaid agencies, and it required state Medicaid agencies to use the transferred information to initiate an MSP application. SSA was also required to make information on MSPs available to those potentially eligible for LIS, coordinate outreach for LIS and MSPs, and train staff on MSPs.²⁵ In addition to the above requirements, MIPPA included a number of other provisions related to MSPs. As mentioned earlier, MIPPA amended the asset limits for QMB, SLMB, and QI to more closely align with the limits for LIS. It also required CMS to translate a previously developed model MSP application into 10 languages other

²⁵MIPPA, § 113, 122 Stat. at 2503 (amending section 1144(c) of the SSA; codified at 42 U.S.C. § 1320b-14(c)(2010)).

than English.²⁶ In addition, MIPPA included funding for states and other organizations to perform outreach for LIS and MSPs.²⁷ Beginning January 2010, MIPPA also exempted certain types of income and assets from being counted when SSA makes a determination of LIS eligibility.²⁸ For example, the law required that SSA not count the value of a life insurance policy as an asset. The law did not extend these changes to MSPs, but states have the option to make comparable changes to their programs. The treatment of the value of life insurance is one example of a potential difference in how LIS and MSPs count income and assets in determining program eligibility.

In addition to the application transfers required under MIPPA, there are a number of other pathways to enrollment in MSPs. First, when a person applies for Medicaid, states may screen them for eligibility for MSPs. Second, some states offer a streamlined application to apply specifically for enrollment in MSPs. Finally, more than half of states automatically enroll beneficiaries whom SSA has determined to be eligible to receive SSI benefits. Once enrolled in MSPs, states periodically determine whether beneficiaries remain eligible for the program and either renew or cancel enrollment. States have different processes for doing this, some of which require more steps by the enrollee than others.

²⁶MIPPA, § 118, 122 Stat. at 2507 (amending section 1905(p)(5)(a) of the SSA; codified at 42 U.S.C. § 1396d(p)(5)(A) (2010)). CMS translated the model application into: (1) Arabic, (2) Chinese, (3) Creole, (4) Farsi, (5) French, (6) Korean, (7) Russian, (8) Spanish, (9) Tagalog, and (10) Vietnamese. States are not required to use the model application.

²⁷MIPPA, § 119, 122 Stat. at 2508. State Health Insurance Assistance Programs, Area Agencies on Aging, and Aging and Disability Resource Centers received MIPPA outreach grants beginning in fiscal year 2009.

²⁸MIPPA, § 116, 122 Stat. at 2507 (amending section 1860D-14(a)(3) of the SSA; codified at 42 U.S.C. § 1395w-114(a)(3)(2010)).

SSA Transferred Applications, Conducted Outreach and Training, and Reported That These Efforts Did Not Significantly Affect Workload

In implementing the MIPPA requirements, SSA reported transferring over 1.9 million applications to states, made information available on MSPs to potentially eligible individuals, conducted outreach, and provided training to staff on MSPs. SSA spent about \$12 million in the first 3 years in implementing the MIPPA requirements, and officials reported that these efforts did not significantly affect its workload.

SSA Transferred over 1.9 Million Applications to States, Made Information on MSPs Available to Potentially Eligible Individuals, and Trained Staff

As required by MIPPA, SSA began transferring applications in January 2010, and SSA reported transferring over 1.9 million applications to states between January 4, 2010, and May 31, 2012. SSA officials told us that all states were able to receive LIS data when the transfers began in January 2010 and that applications are transferred to states each business day.²⁹ Through the application transfer, SSA provides states with the following information: (1) all of the information reported by the applicant or modified by SSA, including information on household composition, income, and assets;³⁰ (2) whether SSA approved or denied LIS enrollment and the reasons for denials; and (3) the date that the LIS application was submitted, as eligibility for SLMB, QI, and QWDI is retroactive to that date. SSA decided that transfers would occur after SSA determined eligibility for LIS, which generally occurs within 30 days.³¹ As a result, a number of elements of the application information transferred to states

²⁹SSA does not transfer LIS data to states on federal holidays.

³⁰LIS application income and assets data include the total amount of income not earned from working (referred to as unearned income), such as Social Security benefits and Veterans Administration benefits; the total amount of income earned from working; the net earnings and losses from self-employment; funds in bank accounts; funds in stocks, bonds, and other investments; and the value of real estate (exclusive of the primary home). SSA officials told us that in reviewing the application, the agency will sometimes modify the reported information after discussions with the applicant. Those modifications are reflected in the data transferred to states.

³¹SSA reported that in fiscal year 2011 about 64 percent of LIS determinations were made in 30 days or fewer and about 90 percent in 45 days or fewer.

have been verified by SSA.³² However, the timing of the transfer can affect benefits for certain applicants. Specifically, for those individuals enrolling in the QMB program, where benefits do not begin until the month after the state's determination of eligibility, waiting for the SSA data transfer may result in the loss of a month or more of benefits.

SSA coordinated with CMS officials and state Medicaid agency officials about how to structure the exchange of application data. For example, SSA developed a standard data transfer agreement and signed an agreement with each state. In the months prior to implementation, SSA tested the data exchange with states in order to identify and resolve any concerns states had in receiving and using the transferred data. Finally, SSA programmed its data systems to transfer the applications as agreed with the states. SSA officials also told us that the agency designed the process to eliminate duplicate applications, applications with insufficient address data, and applications where the individual has opted out of the data transfer. In response to concerns raised by states once the transfers began, SSA also decided to delay the transfer of applications from individuals not yet eligible for Medicare until the applicant is within 1 month of eligibility. For 2011, SSA reported transferring 66 percent of all LIS applications where SSA determined eligibility to states to initiate an application for MSPs; and 13 percent of applications had applicants who opted out of the transfer and thus were not transferred. SSA officials told us the remaining 21 percent were not transferred for various other reasons beyond the applicant opting out of the transfer, such as the applicant was not yet eligible for Medicare or the applicant submitted a duplicate application.

To implement the requirements to make information available to potentially eligible individuals and coordinate outreach, SSA took several steps. SSA made information, such as the model MSP application developed by CMS, available through its website and in local offices. SSA conducted an outreach campaign in 2009 to provide information on LIS and MSPs, including the changes that MIPPA made to the eligibility requirements for both programs. As part of the campaign, SSA held events and issued new promotional materials, which the agency provided to local Social Security offices, community organizations, and health

³²SSA officials noted that SSA verifies some but not all of the information provided by applicants. For example, SSA verifies that certain types of reported income are accurate but does not verify the household size reported by the applicant.

providers' offices. SSA also sent about 2 million outreach letters in 2009 to individuals previously denied LIS benefits alerting them that eligibility requirements for LIS and MSP would be changing in January 2010 and they could now be eligible for LIS as well as MSPs. Since January 2010, SSA has sent letters describing LIS and MSPs to several categories of potentially eligible individuals.³³ (See table 3.)

Table 3: Social Security Administration (SSA) Letters Sent to Individuals Potentially Eligible for Medicare Savings Programs (MSP), 2010 through May 2012

Category of potentially eligible individual	Number of letters sent in 2010		Number of letters sent in 2011		Number of letters sent in 2012 (January-May)	
	English	Spanish	English	Spanish	English	Spanish
Individuals with incomes that appear to qualify for the Low-Income Subsidy (LIS) program and MSPs but not enrolled in either	3,268,289	51,996	2,747,919	42,361	2,344,620	35,725
Individuals with incomes that appear less than 135 percent of federal poverty level, enrolled in LIS, but not enrolled in an MSP	559,469	30,588	792,595	35,828	716,339	34,804
Former disability insurance individuals who lost Medicare Part A premium assistance when they returned to work and who are not enrolled in Medicaid	42,584	514	42,290	511	0 ^a	0 ^a
Total	3,870,342	83,098	3,582,804	78,700	3,060,959	70,529

Source: SSA.

Note: According to SSA officials, in addition to the letters described in this table, SSA sends letters with a LIS application to individuals receiving social security benefits and potentially eligible for LIS as they approach age 65 or the 25th month of disability.

^aSSA generally sends letters to former disability insurance individuals at the end of November of each year.

To train staff, SSA developed two video trainings for its employees on the MIPPA changes to LIS and MSPs and made the video trainings available on-line. SSA required those staff that would be interacting with individuals potentially eligible for LIS or MSPs to view the video trainings prior to January 2010. SSA also updated its policies and procedures manual to include instructions for employees in handling individuals' questions about MSPs during routine contacts. For example, SSA's policies and procedures manual instructs employees to tell individuals about the

³³According to SSA officials, SSA also sends letters with a LIS application to individuals receiving social security benefits and potentially eligible for LIS as they approach age 65 or the 25th month of disability.

availability of MSPs and that in applying for LIS the individuals can initiate an MSP application with their state Medicaid agency unless they opt out. SSA's manual also instructs employees not to help complete MSP applications but to refer individuals with MSP questions to either their local Medicaid office or to State Health Insurance Assistance Programs, which help individuals complete applications for Medicare and Medicaid benefits.

SSA Spent about \$12 Million in the First 3 Years and Reported That Implementing the Requirements Did Not Significantly Affect SSA's Workload

In fiscal years 2009 through 2011, SSA spent about \$12 million to implement the MIPPA requirements. Of the \$24.1 million appropriated by MIPPA for the initial costs of implementing the requirements, SSA spent \$9.2 million combined for fiscal years 2009 and 2010 (\$4.5 million and \$4.7 million respectively). The remaining \$14.9 million in unspent funds remains available to SSA for future costs in meeting the requirements. In fiscal year 2011, SSA spent about \$2.5 million of the \$3 million appropriated under MIPPA for the ongoing administrative costs of carrying out the requirements. These costs were financed through its first annual agreement with CMS. For fiscal year 2012, CMS agreed to fund \$2.8 million. SSA officials told us that, based on data available as of July 2012, they expected SSA's workload, and therefore costs, to remain constant for fiscal year 2012.

SSA officials told us that implementing the MIPPA requirements has not affected SSA's overall workload significantly as measured by the staff time committed to implementation and to handling inquiries and calls about MSPs. For example, SSA officials reported that implementation required 17 full time equivalents (FTE) in 2009, 32 in 2010, and 8 in 2011 and indicated that the ongoing cost in staff time of meeting the requirements is relatively small.³⁴ SSA officials told us that a larger amount of staff time was used in 2009 and 2010 because that was when SSA conducted its outreach campaign and designed and launched the application transfers, the latter of which required programming data systems, developing new procedures, and training staff. According to officials, some of the ongoing staff time will be dedicated to responding to inquiries and calls about MSPs. While SSA data indicated that the volume of field office inquiries and calls to its toll-free line related to MSPs

³⁴SSA defines an FTE as the equivalent of a staff member (or combination of staff members) that worked 2,080 hours. The FTE numbers cited for annual MSP-related activities includes the work of staff at both SSA headquarters and field offices.

increased since the requirements took effect, the volume was relatively small compared to the overall volume of inquires and calls SSA received. For example, in fiscal year 2011, SSA received about 53,000 calls related to MSPs out of a total of 76.8 million fielded through the toll-free line.

SSA officials also reported that, for fiscal year 2011, SSA was under a hiring freeze. As a result, SSA officials noted that FTEs that had been devoted to MSP work have been diverted from some of SSA's more traditional workloads, such as processing claims for Social Security benefits or issuing Social Security numbers. However, the funding appropriated under MIPPA supported the relatively small number of FTEs used to implement the requirements and will continue to do so through the funding agreements with CMS. MIPPA prohibits SSA from using its own administrative funding to carry out the MSP requirements, and, therefore, SSA intends to continue to rely on funding provided under the CMS funding agreements for these activities.³⁵

Estimated MSP Enrollment Increased from 2007 through 2011 with the Largest Increases Occurring after the Requirements Took Effect

Using CMS data, we estimated that MSP enrollment increased each year from 2007 through 2011. The largest increases in MSP enrollment occurred in 2010 and 2011 (5.2 percent and 5.1 percent respectively), the first 2 years that the MIPPA requirements were in effect. (See table 4.) During this period, Medicare enrollment also grew by approximately 2 to 3 percent each year, from about 44.4 million people in 2007 to about 48.7 million people in 2011.³⁶

³⁵See MIPPA § 113(a), 122 Stat. 2503, 2504 (adding SSA § 1144 (c)(5)). SSA uses its annual administrative funding to administer various services, including the Old Age and Survivors Insurance, Disability Insurance, and SSI programs, among other services, and provide certain administrative support for programs primarily administered by other agencies, such as Medicare.

³⁶See Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *The 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: Apr. 23, 2012).

Table 4: Change in Estimated Medicare Savings Program (MSP) Enrollment, 2007 through 2011

Month/year	Estimated MSP enrollment	Estimated annual increase in enrollment	Annual percentage increase
December 2007	6,740,940	233,190	3.6%
December 2008	7,002,427	261,487	3.9
December 2009	7,195,390	192,963	2.8
December 2010	7,572,541	377,151	5.2
December 2011	7,961,274	388,733	5.1

Source: GAO analysis of CMS data.

Notes: These data provide an estimate of the number of Medicare beneficiaries enrolled in MSPs in December of the given year and the annual change in enrollment nationally. The data do not include individuals enrolled in the Qualified Working and Disabled Individuals program. The data may include some beneficiaries who are not enrolled in MSPs for whom states finance Medicare Part B premiums.

A number of factors may have contributed to the higher levels of growth in MSP enrollment in 2010 and 2011, including SSA application transfers and outreach, other MIPPA provisions and related changes to state policies, and the economic downturn.

- SSA application transfers.** In response to our survey of state Medicaid officials about the effects of the application transfers on MSP enrollment, officials from 28 states reported that MSP enrollment has increased as a result of the application transfers. In contrast, officials from 12 states reported that the application transfers did not have an effect on MSP enrollment, and officials from the remaining 10 states reported they did not know the effect of the transfers.³⁷ While there are no nationwide data that demonstrate the effects of the SSA application transfers on MSP enrollment, 3 of the 6 states we contacted to supplement our survey tracked some information on the outcomes of applications transferred by SSA.³⁸ As a result of the application transfers from SSA in 2011, Arizona reported enrolling about 800 of 16,000 applicants; Louisiana reported enrolling about

³⁷ Officials from the remaining state did not answer the survey question about the effects of the application transfers on MSP enrollment.

³⁸ SSA collected data on the number of people who applied for LIS and were enrolled in an MSP in 2010 and 2011, about 280,000 individuals each year. SSA officials explained that the data are limited in that SSA cannot determine whether those enrolled in an MSP were enrolled as a result of their LIS application triggering an MSP application or because of a duplicate MSP application submitted to the state.

3,300 of about 21,800 applicants; and Pennsylvania officials reported enrolling about 16,000 of 37,500 applicants. It is not clear, however, if these beneficiaries would have enrolled in MSPs through other means if the application transfers had not been in place. For example, these enrollees may have instead enrolled by applying directly through the state.

- **SSA outreach.** As previously mentioned, SSA completed an outreach campaign in 2009 and has sent letters with information about MSPs to millions of potentially eligible individuals. Our prior work indicates that letters sent by SSA to potentially eligible individuals in 2002 resulted in more beneficiaries enrolling in MSPs than would have likely enrolled without receiving an SSA letter.³⁹
- **Other MIPPA provisions.** The MIPPA provision that more closely aligned asset limits for MSPs with the limits for LIS expanded the number of beneficiaries eligible for MSPs in 2010. Specifically, the requirement effectively expanded eligibility in 41 states by increasing the asset limits.⁴⁰ In addition, MIPPA-funded outreach conducted by states and other organizations that began in 2009 may have increased the likelihood that applications resulted in enrollment. According to data from the National Council on Aging (NCOA), the national resource center funded to track the outreach, grantees assisted about 200,000 individuals from January 2010 through December 2011 in submitting a complete MSP application.⁴¹ NCOA reported that grantees in most states are able to access the applications transferred by SSA to identify those beneficiaries who potentially need assistance completing the MSP application.

³⁹GAO-04-363. Using SSA data, we estimated that of the 16.4 million people who received SSA letters in 2002, an additional 74,000 recipients enrolled in MSPs than would have likely enrolled without the mailing.

⁴⁰Of the remaining 10 states, 9 did not consider a person's assets when determining eligibility for MSPs, and therefore the MIPPA requirement did not expand eligibility in those states. They are Alabama, Arizona, Connecticut, Delaware, the District of Columbia, Maine, Mississippi, New York, and Vermont. The final state, Minnesota, had asset limits that were higher than the LIS limits prior to January 2010.

⁴¹NCOA defines assistance as providing follow up or resolving problems with an application that was (1) denied by the state, (2) delayed beyond the 45-day limit for determining eligibility, or (3) found to be incomplete by the state. The grantees are to provide enough assistance to individuals so that the state can process the application.

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- **Economic downturn.** It is unclear how the economy affects the population potentially eligible for MSPs. In 2011, we reported that during the economic downturn, from 2007 through 2010, unemployment among those aged 65 and older doubled and food insecurity increased.⁴² In addition, awards of SSA disability benefits to those ages 50 to 64 increased.⁴³ However, our past work also found that the percentage of adults 65 and older with incomes below 200 percent of the federal poverty level did not increase.⁴⁴

States Reported That the Requirements Led to Various System Changes and Increased Workload

Officials from four of the six states we contacted to supplement our survey reported making changes to Medicaid eligibility systems, specifically, changes to both information systems and business processes, to receive and act upon the applications transferred by SSA. For example, officials from Arizona reported modifying the state's information system to accept the data and automatically create records for the individuals in the eligibility system and generate notification letters asking the applicants for additional information in order to complete the application. Officials also said that the state established new business rules for processing applications received through the transfers. Officials from Colorado, one of the two states that did not report making changes, told us that the state plans to make changes to its system pending the availability of funding to implement the changes. Because the state did

⁴²We found that among elderly households with incomes below 130 percent of FPL, the proportion classified as food insecure rose from 17.6 percent in 2006 to 24.0 percent in 2010. The U.S. Department of Agriculture identifies families with food insecurity based on responses to questions in a supplement to the Current Population Survey concerning the inability, at times, to afford balanced meals, cutting the size of meals because of too little money for food, or being hungry because of too little money for food. Households are classified as having low or very low food security if they experienced the condition at any time during the previous 12 months. GAO, *Income Security: Older Adults and the 2007-2009 Recession*, [GAO-12-76](#) (Washington, D.C.: Oct. 17, 2011).

⁴³The Kaiser Commission on Medicaid reported that Medicaid enrollees that are aged or living with disabilities are less sensitive to changes in economic conditions than other populations, such as children. However, using data reported by 45 states and Washington, D.C., they found that Medicaid enrollment for the aged and disabled grew by 4 percent from December 2009 to December 2010 as compared to increases of 3.4 percent and 2.7 percent in the two preceding 12-month periods. See Kaiser Commission on Medicaid Facts, *Medicaid Enrollment: December 2010 Data Snapshot* (Washington, D.C.: December 2011).

⁴⁴Additionally, the percentage of adults 65 and older with incomes below 100 percent of the poverty level declined from 9.7 percent in 2007 to 9.0 percent in 2010. See [GAO-12-76](#).

not have the funds to make the necessary system changes, officials said that they had to develop an interim process, under which transferred applicants receive an assessment of MSP eligibility only if the applicant completes the state's request for additional information.⁴⁵ Officials from the final state, Pennsylvania, told us that the state did not make changes to its information system as a result of the application transfers but did establish business processes for sorting the applications and forwarding them to county assistance offices for processing.

Officials from five of the six states said that the application transfers had increased the state's workload—the time spent processing applications for MSP enrollment—to some extent and that the additional work was absorbed by existing staff.⁴⁶ While states were able to make MSP determinations and generate notifications without the need for caseworker involvement for some of the 1.9 million applications sent by SSA since the transfers began in January 2010, other cases required follow-up calls with the applicant or cross-checking the data with other data sources for verification. Colorado, one of the five states reporting an increase in workload, provided data showing that the state received around 15 percent more applications in 2010 and 2011 than in 2009. However, officials from Pennsylvania, another of the states that reported an increase in workload, indicated that the effect was minimal. Pennsylvania officials noted that, while transfers have increased the volume of applications, processing applications for MSP is a relatively small portion of caseworkers' overall workload. Officials noted that caseworkers process many more applications for other programs such as Medicaid and the Supplemental Nutrition Assistance Program than for MSPs. Officials from Louisiana, the one state that did not report an

⁴⁵Under the state's interim process, which was reviewed by CMS for compliance with the requirements, the state receives the transfers in a stand-alone database. That database generates notifications to transferred applicants that to be considered for MSP eligibility they must contact their county social service office or visit the state website to complete an application. If the person submits an application and the notification letter documenting the date of LIS application, the state will determine eligibility and, upon approval, will use the LIS application date when determining eligibility for MSPs. If the person does not submit the application, no determination of eligibility is made and there is no record of an application in the state's eligibility system. Once the state's system is updated, all applicants transferred by SSA will receive an eligibility determination for MSPs.

⁴⁶Officials from the final state said that they could not determine the effect of the application transfers on the state's workload, including the effect on the volume of applications received.

increased workload, said that it is difficult to determine the effect of the application transfers but that for some applications the transfers had reduced the time needed for processing.

States identified several reasons why processing the applications transferred from SSA had increased their workload, including that the transfers include applications for those who are clearly ineligible for MSPs, applications have inaccurate information, and applicants do not understand that their application for LIS is triggering an application for MSPs.

- The increased workload may have resulted from SSA transferring applications for individuals who are ineligible for MSPs because their income or assets exceed the federal MSP eligibility limits or they are not yet eligible for Medicare.⁴⁷ In response to our survey, officials from one state reported that over 70 percent of the applications received from SSA are ineligible for the state's MSPs but that the state is still required to process the application. The officials noted that processing these applications is not a productive use of limited state resources. Officials from Pennsylvania, one of the six states we contacted to supplement our survey, reported that, of the approximately 37,500 applications transferred by SSA in 2011, about 14,600 had been denied LIS enrollment. Those rejected applicants represented a significant majority of the 21,600 rejected by the state for MSP enrollment. Officials told us that they have adjusted their process to automatically deny enrollment in MSPs for those individuals that were rejected by SSA for LIS because, for example, the person did not have Medicare or had income that exceeded the eligibility limits.
- In response to our survey and during interviews, officials from several states reported inaccuracies in the SSA data that may have made the applications more difficult for states to process. For example, Louisiana officials told us that the city of an applicant is sometimes misspelled in the SSA data. This triggers an error in the state's system, which must be reviewed and corrected by the state.

⁴⁷ SSA officials told us that soon after application transfers began, SSA modified its process to delay transferring applications for those not yet eligible for Medicare until the applicant is within 1 month of eligibility. However, officials from several states reported that their states continue to receive applications for individuals who are more than 1 month away from being eligible for Medicare.

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- In response to our survey, officials from several states also indicated that the state spends time requesting information from applicants who do not provide it because they do not understand that they have applied for MSPs. For example, officials from Virginia commented that individuals do not realize that their application for LIS is triggering an application for MSP and do not end up providing the additional information needed for the state to make a determination of MSP eligibility. Arizona officials stated similar concerns and provided data indicating that 63 percent of all of the applications transferred by SSA and processed by the state in 2011 were denied because the applicant did not respond to the state's request for additional information.

The extent to which the SSA application transfers required system changes or affected workload may have depended on whether the state treated the transferred information as verified. Though CMS policy allows states to treat the information in the transferred applications as verified, in response to our survey, officials from 35 states reported requiring applicants to reverify some or all of the information before the state would determine eligibility for MSPs. States most frequently reported requiring applicants to reverify income, both earned and unearned, and assets.⁴⁸ (See table 5.) Nine states reported requiring applicants to reverify all of the data elements transferred by SSA, including household size and identity.

⁴⁸Our survey did not ask states whether the state's methods for determining eligibility for MSPs were consistent with those used for LIS.

Table 5: Social Security Administration (SSA) Data Elements States Require Medicare Savings Program Applicants to Reverify

Data element transferred by SSA	Number of states requiring reverification
Earned income	30
Assets	29
Income not from work	28
Household size	19
Identity	11

Source: GAO survey of state Medicaid officials.

Note: Of the 51 states that responded to our survey, officials from 35 states reported requiring applicants to reverify one or more of the data elements transferred by SSA; officials from 15 states reported not requiring applicants to reverify any of the information; and officials from 1 state did not answer the relevant survey question.

In the six states we contacted, we found some evidence to suggest that the application transfers had less of an effect on workload in states that treated the transferred information as verified. Specifically, of the three states that we contacted that accepted SSA’s verification of the application information, two states reported being able to enroll some of the transferred applicants with little to no work required of caseworkers. Louisiana officials said that the transfers have allowed the state to autoenroll some applicants (where the eligibility system enrolls the applicant using the data transferred by SSA with no need for a caseworker to enter data or contact the applicant). For example, from March 2010 through January 2012, Louisiana autoenrolled about 14 percent of applicants transferred by SSA (5,937 of 43,414).⁴⁹ Officials said that the transfers have reduced the workload for these applications. Similarly, officials from Pennsylvania said that the number of applications received from SSA where caseworkers need to contact applicants for more information was small, because, in addition to treating the information as verified, the state has access to 12 different data sources that can be used to address any discrepancies in the SSA data and provide asset information that is not included in the SSA data.⁵⁰ In contrast, in the three states we contacted that required applicants to

⁴⁹Louisiana’s data indicated that, despite treating the SSA data as verified, about 25 percent of applications received from SSA in 2011 required involvement of a caseworker.

⁵⁰For example, the state reported accessing data from the Internal Revenue Service on earned and unearned income.

reverify some of the information (Arizona, Colorado, and Florida), the verification process included applicants reporting and documenting income and reporting and attesting to the accuracy of other information, such as assets and citizenship. This verification process included multiple steps by states and applicants.

Differences in how SSA and states count income and assets for LIS versus MSPs may have driven states' choices to require further verification of information in the transferred applications. For example, several states noted that the LIS application combines income for a couple, whereas the state needs to know the income for each spouse separately to determine eligibility for MSPs. Officials from Arizona, one of our selected states that requires applicants to reverify income, explained that the state needs to know the income of each spouse as well as any dependent children living in the household to determine eligibility for MSPs. In a February 2010 letter to state Medicaid directors with guidance on implementation of the MIPPA requirements, CMS noted that SSA has a more expansive definition of a household in determining eligibility for LIS than what most states use to determine MSP eligibility. The guidance reminded states that they have the option to align their definition with SSA's, and noted that doing so would expand eligibility for MSPs to more people and reduce states' administrative burden in processing the applications transferred by SSA. Some states also count certain types of income and assets that SSA does not. For example, SSA does not count the value of life insurance policies against the asset limit, but states count it unless the state has amended its Medicaid plan to disregard it. States must verify whether applicants have life insurance policies either by contacting the applicant or through another data source.

Concluding Observations

Historically, MSPs have had low enrollment rates, with the Congressional Budget Office estimating in 2004 that only a third of eligible individuals were enrolled in the QMB program and an even smaller percentage in the SLMB program. Our estimates show that enrollment has grown each year for the last 5 years, with the largest increases occurring in 2010 and 2011 (5.2 percent and 5.1 percent), the first 2 years the MIPPA requirements were in effect. The differences between how income and assets are counted for LIS and MSPs make it difficult for some states to act on the applications transferred by SSA without requiring additional information from applicants, a step that requires additional work by the state and can present a hurdle to applicants. Aligning the methods for determining income and assets for MSPs with those of LIS is an option currently available to states, and some states have used that flexibility. More states

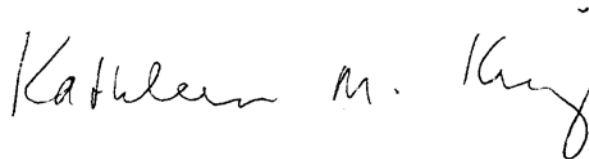
may not have opted to do so because aligning these methods would likely expand the number of individuals who are eligible only for MSP, and not for other Medicaid, benefits. Because providing MSP benefits to such individuals is likely to increase costs to the state, states have no immediate financial incentive to provide MSP benefits to these individuals. Further, while aligning these methods may allow states to more easily act upon the applications transferred by SSA, it would create a method for counting income and assets for MSPs that may differ from how states assess eligibility for Medicaid, making it more complicated for states to assess MSP eligibility as part of assessing eligibility for Medicaid.

Agency Comments

We provided a draft of this report to HHS and SSA to review. HHS did not provide comments. SSA stated, in an e-mail, that the report accurately describes its implementation of the requirements. SSA also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Administrator of CMS, the Commissioner of SSA, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.



Kathleen M. King
Director, Health Care

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Appendix I: GAO Methodology for Estimating Change in Medicare Savings Program Enrollment

To describe the change in Medicare Savings Program (MSP) enrollment from 2007 through 2011, we used data from the Centers for Medicare & Medicaid Services (CMS) to estimate annual enrollment and the change in annual enrollment over that period. The data, reported by states to CMS, included state-level information on the number of Medicare beneficiaries for whom states will pay the Medicare Part B premium.¹ For our estimates we used data that represented the number of beneficiaries for whom states financed the Part B premium in December of each year. The data do not reflect enrollment for Qualified Disabled and Working Individuals, which CMS officials estimated numbered less than 300 people nationally as of March 2012. In addition, the data include some Medicare beneficiaries who are not eligible for MSPs but for whom states finance the Part B premium. We excluded some but not all of these beneficiaries from our analysis. Specifically, we excluded those beneficiaries categorized as “medical assistance only” as those beneficiaries are not eligible for MSPs per CMS’s policy manual. We were not able to exclude those categorized as “medically needy”—beneficiaries who may or may not also meet the eligibility requirements for an MSP—because CMS does not have data on this population for each of the years in our analysis. It is also likely that for a small percentage of beneficiaries, states did not specify the basis of eligibility, and therefore it is unclear whether they were eligible for MSPs or not. While CMS does not have data for each of the years in our analysis on the number of beneficiaries categorized as medically needy or with an unspecified eligibility category, 4 percent were medically needy and 4 percent did not have an eligibility category specified as of May 8, 2012. Though our estimates of enrollment may be overstated, we believe that our estimates of the change in enrollment over the 5-year period are valid.

To assess the reliability of CMS’s data on MSP enrollment, we interviewed CMS officials about their efforts to ensure the quality of the data and reviewed the CMS policy manual outlining the requirements states must follow in reporting the data. We also asked officials about the limitations of the data and reviewed any statements about data limitations in published reports. Finally, we reviewed data for each month of 2007

¹The data were derived from CMS’s monthly Third-Party Buy-In file, which contains data from the CMS Enrollment Database. Data in the Enrollment Database are used by CMS to track enrollment and bill state Medicaid programs for the Part B premiums for individuals whose premiums the state has agreed to finance. States submit data regularly to CMS for updates to the Enrollment Database.

through 2011 to identify any anomalies in the data. We determined the data to be sufficiently reliable for the purposes of estimating the changes in MSP enrollment nationally over time; where relevant we stated the limitations of the data in the findings.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Kathleen M. King, (202) 512-7114, kingk@gao.gov

Staff Acknowledgments

In addition to the contact named above, Kristi Peterson, Assistant Director; Jeremy Cox, Assistant Director; Susan Barnidge; Krister Friday; Sandra George; Kristin Helfer Koester; Lisa Rogers; and Paul Wright made key contributions to this report.

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