MIPPA – Three Years On

In 2008, Congress enacted the Medicare Improvements for Patients and Providers Act (MIPPA), an extensive piece of legislation that included provisions to strengthen Medicare for low-income beneficiaries, reduce racial/ethnic disparities among Medicare patients, and increase accountability measures for Medicare Advantage programs, among other provisions. Through MIPPA, the federal government also allocated funding for the aging network to increase outreach to people with Medicare, especially those with limited incomes and resources.

Specifically, MIPPA provided targeted funding for State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), and Aging and Disability Resource Centers (ADRCs) to assist low-income Medicare beneficiaries to access the key benefits that make Medicare affordable—namely, the Part D Low Income Subsidy (LIS/Extra Help), and the Medicare Savings Programs (MSPs)1—and to assist rural residents to enroll in Part D. MIPPA also supported the National Center for Benefits Outreach and Enrollment (the “Center,” housed at the National Council on Aging/NCOA) to provide tools, technical assistance, and resources to SHIPs, AAAs, and ADRCs responsible for helping low-income seniors.

The first MIPPA funds were disbursed in 2009 to 51 state and territorial grantees and the District of Columbia. Two years later, in 2010, the Affordable Care Act provided another round of funding for MIPPA grantees and the Center, and included an additional directive—to educate Medicare beneficiaries about the new free preventive services covered by Medicare and to encourage their utilization.2

Following the end of the first three years of MIPPA funding, the grantees submitted reports to the Center regarding their successes, challenges, lessons learned, and recommendations, which are summarized in this report.

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1 The Part D Low-Income Subsidy (LIS/Extra Help) helps people afford their prescriptions by paying all/part of the cost of their monthly plan premium and providing meaningful discounts on prescriptions at the pharmacy. The Medicare Savings Programs (MSPs)—which include the Qualifying Individual (QI) program, the Specified Low-Income Medicare Beneficiary (SLMB) program, and the Qualified Medicare Beneficiary (QMB) program—are run through state Medicaid offices, and provide support to help pay the costs of Medicare Part B.

2 Two states funded under the first round of MIPPA—Florida and Mississippi—opted not to receive funding through the Affordable Care Act. A third round of MIPPA funding was included in the American Taxpayer Relief Act of 2012, passed by Congress on Jan. 1, 2013. As of early April 2013, this funding has not yet been disbursed to the states.
Results

In the three years of MIPPA funding, grantees have helped millions of low-income people with Medicare to afford their prescriptions and health care. As Figure 1 illustrates, SHIPs, AAAs, and ADRCs submitted more than 690,000 applications for LIS and MSP, worth a combined $1.9 billion in benefits.

**Figure 1. Benefits applications submitted by MIPPA grantees and their value**

<table>
<thead>
<tr>
<th>APPLICATION TYPE</th>
<th>2009 (Jun-Dec)</th>
<th>2010 (Jan-Dec)</th>
<th>2011 (Jan-Dec)</th>
<th>2012 (Jan-Jun)</th>
<th>Total</th>
<th>TOTAL VALUE OF BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIS applications</td>
<td>46,328</td>
<td>116,816</td>
<td>123,594</td>
<td>73,764</td>
<td>360,502</td>
<td>$1,437,375,200</td>
</tr>
<tr>
<td>MSP applications</td>
<td>31,594</td>
<td>87,589</td>
<td>112,005</td>
<td>99,232</td>
<td>330,420</td>
<td>$491,464,214</td>
</tr>
<tr>
<td>TOTAL</td>
<td>77,922</td>
<td>204,405</td>
<td>235,599</td>
<td>172,996</td>
<td>690,922</td>
<td>$1,928,839,414</td>
</tr>
</tbody>
</table>

One of the initial challenges presented by MIPPA was to better coordinate the application and eligibility processes for the LIS and MSP programs. While LIS is administered at the federal level by the Social Security Administration (SSA), the MSPs are managed by each state’s Medicaid office. MIPPA helped to develop a more seamless system whereby information contained within an LIS application was automatically transferred to the state Medicaid agency to initiate an MSP application. While there were some initial hurdles with the transfer of data from SSA to the state Medicaid office, over the three-year grant period, this data transfer process steadily improved. As time progressed, more MSP applications were begun and completed in most states (see Figure 2). The states that showed the highest growth in their MSP submissions were those that secured data-sharing agreements with their state Medicaid offices so that they could assist in processing the MSP applications that are triggered by LIS data that is sent to state Medicaid agencies by SSA. Under these agreements, MIPPA grantees provide additional support to the Medicaid offices to complete the MSP applications and gather the additional documentation required. At the end of the grant period, six states (Delaware, Hawaii, Iowa, Minnesota, South Carolina, and Wisconsin) had signed an agreement and several others were in the process of developing one.
States also discovered other mechanisms to ease the process of enrollment into MSP. Some states, including Arizona, Connecticut, Delaware, Maine, New York, and Vermont, have waived asset requirements for their MSPs, while others, like Nevada and New York, have simplified their MSP applications. In Connecticut, after the state’s pharmaceutical assistance program was closed to people with Medicare, the state increased its MSP eligibility limits to align with the eligibility limits of ConnPACE. Likewise, the MIPPA lead agencies and the Center played a key role in educating their networks about the importance of the MSPs, the different pathways to these benefits, and the value of simultaneous applications for those who are eligible for both LIS and MSP.

An independent evaluation conducted by the Government Accountability Office found that enrollment in MSPs increased each year between 2007 and 2011 (the last date for available data at the time of their report), with significant increases in 2010 and 2011. As the report notes:

*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. 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.*

Further analysis of the data by the Center suggests that MIPPA resulted in a 19:1 return on investment ratio, as illustrated in Figure 3. The $61.4 million awarded to the states resulted in close to 700,000 applications for LIS and MSP. Data from the SSA and the Centers for Medicare & Medicaid Services (CMS) estimates the annual per beneficiary value of LIS at

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$4,000 and MSP at $1,405 (in 2012). Based on additional data submitted by partners, the Center estimates that roughly 60% of applications are accepted and result in enrollments into these programs. Thus, every $1 spent on MIPPA activities translated into $19 in benefits for low-income Medicare beneficiaries.

**Figure 3. Return on investment of MIPPA funding**

- $61.4 million in MIPPA grants
- 690,000 applications worth $1.9 billion
- 60% likely to receive the benefit
- $19 in benefits for low-income seniors per $1 of MIPPA grant

**Key achievements beyond the numbers**

Aside from the quantitative evidence, many grantees can point to other achievements and measures of success in their communities that resulted from the MIPPA funding. These achievements included reaching new populations, developing more person-centered systems of client service, building partnerships both inside and outside the aging network, increasing uptake of preventive services, and expanding training opportunities for agency staff and community partners.

**Reaching new populations**

One success of the MIPPA funding was that agencies were able to make contact with and assist populations that had previously been difficult to reach. The grants enabled some SHIPs, AAAs, and ADRCs to hire or engage staff/volunteers from under-represented communities, including speakers of other languages. Likewise, many state agencies reported being able to conduct a greater number of outreach and enrollment activities in rural and tribal areas.

Some of the newly reached populations included:

- Seniors with limited English proficiency
• Native American/Alaskan Native tribal communities
• Disabled adults under age 65
• People aging into Medicare
• Caregivers
• Individuals isolated by geography (rural residents)

The grantees’ ability to reach these new populations was enhanced by the Center’s efforts to mine data in real time and provide technical assistance to states. During the grant period, the Center conducted research on special population demographics in Arizona, Minnesota, and Wisconsin, and presented in-depth workshops with aging network professionals about how to reach these new groups. The Center also published issue briefs and/or hosted webinars on how to reach isolated populations, cultural competence in benefits access, reaching those new to Medicare, and benefits for legal non-citizens.5

**Developing person-centered service systems**

Another key achievement of MIPPA was that it enabled the grantees to streamline access to benefits for their clients. One of the ways this occurred was via a “no wrong door” or single entry point for consumers. Numerous agencies reported that they developed mechanisms to pre-screen clients for benefits at the point of initial contact. These clients would have their immediate need addressed, but also receive referrals and more information about other services available to them. Likewise, many agencies ensured that all of their staff and volunteers—regardless of whether they worked directly under MIPPA—received basic training on the eligibility requirements for LIS and MSP, so that they could actively flag clients who appeared eligible for referrals and follow-up.

As described in more detail below, MIPPA grantees also cultivated partnerships with representatives from senior housing complexes, energy assistance programs, and food banks, among others. These partnerships further facilitated a person-centered approach to benefits access, wherein potentially eligible clients received information on a range of benefits available to them, including food assistance, housing vouchers, energy assistance, and more.

**Building partnerships**

While MIPPA funding was awarded to each of three types of aging agencies in the states—SHIPs, AAAs, and ADRCs—the requirement that each state develop a single proposal helped to facilitate greater collaboration and efficiency, especially among those agencies that were not co-located.

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5 Webinars and issues briefs are available online at the Center’s Resource Library at: [http://www.ncoa.org/enhance-economic-security/center-for-benefits/content-library/](http://www.ncoa.org/enhance-economic-security/center-for-benefits/content-library/)
At the same time, the funding provided each grantee the opportunity to expand its network exponentially. Over the course of the three years, nearly 9,000 local partners were working to assist in achieving the goals of MIPPA. The size and composition of the MIPPA networks vary significantly by state. In general, MIPPA networks are made up a combination of the core MIPPA partners (AAAs, ADRCs, and SHIPs) and partners such as senior centers, pharmacies, libraries, and grocery stores, among many others. Notably, the relative presence of diverse partners increased over time in comparison to the core MIPPA partners. In April 2011, the core MIPPA grantees represented close to 60% of the members of the partnerships. By the end of the grant period, due to the significant increase in the number of other partners, core MIPPA grantees represented less than 40% of the partners in the MIPPA network.

The change in the composition of the MIPPA network reflects two important trends. First, as MIPPA grantees maximized the involvement of their state AAA, SHIP, and ADRC networks, most of the new partnerships emerged outside of the core network. These new partnerships came from community-based organizations, private sector partners, senior centers, and many other organizations that served as host sites to MIPPA outreach and enrollment events and staff.

Another factor that changed the composition of the MIPPA network was the added responsibility in 2010 to promote the prevention and wellness benefits in Medicare. In fact, 7% of the new partnerships created since April 2010 were in the area of prevention and wellness. Furthermore, 59% of all of the MIPPA partners worked on a combination of topics that included benefits outreach (i.e. LIS and MSP) and prevention and wellness (see Figure 4). As part of this work, MIPPA grantees established partnerships with physicians’ offices as well as many local senior center and agencies that host chronic disease self-management programs (CDSMP) and other prevention and wellness activities. These partnerships have helped numerous MIPPA grantees, which in many states are also responsible for CDSMP and other evidence-based programs, to cross-promote their work on benefits and prevention and wellness. This effort ensures that more seniors with multiple chronic conditions have access to the health care and prescriptions that are necessary to successfully self-manage their health.
Another significant trend among grantees has been their success in engaging the private sector. MIPPA grantees developed partnerships with a number of retailers, pharmacy chains, and grocery stores to serve as enrollment sites and to help distribute materials about LIS and MSP. In this process, grantees helped these partners understand that their customers’ access to LIS and MSP benefits fosters economic activity that is beneficial to them and the community.

Two examples of successful partnerships come from the states of North Carolina and Pennsylvania. In North Carolina, one MIPPA grantee developed a partnership with local Wal-Mart stores to serve as a one-day enrollment site. This partnership resulted in many successful applications submitted, and it created greater awareness among many of Wal-Mart clients who were not aware of the existence of LIS and MSP. In Pennsylvania, the SHIP program partnered with Rite Aid to provide pharmacy customers with informational pamphlets.

While there is no data on the longevity of these new partnerships, the additional qualitative data reported by grantees shed light on their disposition. In many states, the partnerships created outside of the traditional MIPPA network were initially developed as time-limited collaborative efforts intended to help MIPPA grantees. However, partnerships such as those developed with Medicaid offices and community action agencies, that seek to cross-promote programs and ensure that Medicare beneficiaries can have greater access to services,
generally lasted for the entire grant period. Many of these partners are trying to continue their collaborative efforts in the absence of funding, and the next round of MIPPA grants will likely lead to further partnerships.

**Increasing use of preventive services**

Medicare offers a range of preventive and wellness services free to beneficiaries, including an Annual Wellness Visit that was created under the Affordable Care Act. The second MIPPA funding award included the promotion of these services as part of the activities to be carried out under the grant.

According to data from CMS, by the end of 2012, some 34.1 million people had accessed one or more of these preventive services. MIPPA grantees, as well as the Center, played a role in this achievement. After hearing that many consumers, counselors, and providers alike remained confused about the distinction between the free Annual Wellness Visit and a general physical exam, the Center staff conducted research and discussions with CMS to clarify this distinction, and produced helpful guides for counselors and consumers. With assistance from CMS, the Center also identified the appropriate billing codes for providers to use for these services, and MIPPA grantees circulated this information as part of their provider education efforts throughout the country.

Some grantees reported that the preventive services enabled them to more easily reach potential low-income beneficiaries, by using health as an entry point to speak about costs and benefits. Other grantees saw the preventive benefits as a unique “gateway to Medicare” opportunity, hosting events focused on what people turning 65 needed to know, and encouraging them to take advantage of the Welcome to Medicare exam, Annual Wellness Visits, and preventive screenings.

Finally, the partnerships between the agencies and health care providers have led to improved referrals, and providers requesting more training and information from SHIPs, AAAs, and ADRCs around benefits.

**Expanding training**

When asked about their ability to sustain the MIPPA effort, many states cited that being able to train a wide array of partners has enabled them maintain the momentum. In addition to educating all staff and volunteers within the SHIPs, AAAs, and ADRCs on the basics of LIS, MSP, and preventive services, many states used the MIPPA funding to train:

- Medicaid and Community Action Agency eligibility workers
- Social workers, case managers, and other staff at health facilities
- Parks and recreation staff
- Volunteers with Meals on Wheels
• Staff of community-based organizations serving special populations (including those working with limited English proficiency seniors and adults with disabilities)
• Native American/Alaskan Native tribes

Many grantees cited frequent training as an effective means of quality control, both among SHIP, AAA, and ADRC staff, and in ensuring that partners had up-to-date knowledge about appropriate times to make referrals, and how to help clients with applications. They also noted that MIPPA funding permitted them to provide training in greater depth—and breadth—incorporating information on combating stigma, preventive benefits, and special populations.

Many counselors have expressed that they derived personal satisfaction in knowing they had the training to better serve their clients in need, as evidenced from this quote from a benefits counselor in Wisconsin:

“Because I took this position during a period of MIPPA funding, the instinct to always talk about these programs and screen for them is automatic. In nearly three years, I have had many clients either gain more health benefits, pay less for health care, or both. This makes the job a great source of satisfaction.”

Challenges that remain

Despite the considerable achievements resulting from the MIPPA funding, there remain several challenges to identifying and enrolling low-income people with Medicare into LIS and MSP. Interestingly, these challenges were fairly consistent across states, despite population and administrative differences.

• Reaching rural and isolated populations. While many grantees stated that the MIPPA funding enabled them to conduct outreach in previously underserved areas, the majority still felt that they were not able to adequately meet the needs of rural residents. Transportation access hampered efforts in many states, especially as many seniors require one-on-one counseling to complete applications for benefits and cannot be accommodated at one-time events.

• Lack of awareness of benefits and supportive programs. Despite the significant efforts of MIPPA grantees to spread the message about the availability of benefits that can help low-income seniors to afford Medicare, there remains a woeful lack of
awareness about these programs among the public. Additionally, many older adults and their caregivers are unaware of the state resources (SHIPS, AAAs, ADRCs) available to help them navigate their concerns about Medicare, insurance, and aging issues.

• **Convincing eligible older adults in need that they deserve the benefit.** Aside from awareness of the programs, many seniors are reluctant to apply for anything that carries the stigma of “welfare” or “government handout.” This was especially challenging to counteract given the current political and economic climate and frequent media attention regarding the need to reduce government spending on public programs.

• **Combatting concerns around asset recovery.** Many grantees noted that older adults continue to believe that enrolling in benefits—particularly the Medicare Savings Programs—would affect their ability to retain assets, such as vehicles, homes, and savings. This misconception may be a result of states using combined MSP and Medicaid applications, and asset recovery being mentioned in relation to Medicaid.

• **Coordinating applications with local offices.** Some MIPPA grantees have had positive experiences developing partnerships with local offices that administer food, energy assistance, Medicaid, and other programs. Yet others complained about serious backlogs and bottlenecks when referring their clients to those offices for assistance with applications. As state budgets are cut further, so too are eligibility staff who process applications and provide assistance at partner agencies.

• **Staffing is subject to funding and state limitations.** Most MIPPA grantees lauded the funding opportunity as a means to hire and train more staff and volunteers to assist with their outreach efforts. In some instances, hiring staff was subject to state-level restrictions or approvals, and some key agency positions remained unfilled for some time. The potential loss of funding (especially as there is a gap of several months between MIPPA 2 and 3) meant that some offices could not retain those staff and had to lay staff off when the grant ended. It is believed that when MIPPA 3 funding is disbursed, there will be some time required to increase staffing levels back to previous performance levels.

**Looking ahead**

When asked to specifically provide recommendations for what the Center and the federal agencies could do to sustain their good work, the SHIPs, AAAs, and ADRCs were unanimous that continuing to fund the MIPPA efforts is essential. As one ADRC counselor from Washington State explained:
“This program is vital. While we will continue to assist individuals who qualify for these programs, finding them could be a difficult task. Without funding for outreach, we fear that many people will fail to get the assistance they need and deserve.”

In addition to funding (which has been temporarily solved for with the passage of the American Taxpayer Relief Act), the MIPPA grantees outlined other means of support that will enable them to maintain/improve their work:

- Ongoing training and technical assistance from CMS and the Center, particularly webinars and updates to the BenefitsCheckUp® screening tool.
- Media materials—such as PSAs, sample press releases, etc.—with a consistent branding and message that can be tailored locally and used to increase awareness of the programs.
- Printed outreach materials, with translations into other languages.
- State and county level data on potentially eligible individuals not enrolled into LIS, which agencies can use better target their outreach efforts.
- Simplification or alignment of application and recertification processes.

Several states suggested the need for a national campaign that not only focuses on LIS and MSP, but also on the existence of SHIPs, AAAs, and ADRCs as local sources of support for anyone who has questions about Medicare.

One of the goals that the Center—as well as many grantees—has articulated for MIPPA 3 is being able to increase referrals and assistance for other benefits that can improve the lives of low-income seniors. Many MIPPA grantees have already begun to look holistically at the health care, food, housing, and other needs of their clients, and have built relationships with local agencies that administer other benefits, such as the Supplemental Nutrition Assistance Program (SNAP) and the Low Income Home Energy Assistance Program (LIHEAP).

The Center has received support from the Atlantic Philanthropies to work comprehensively in Alabama, Colorado, and Cook County, IL to improve the coordination of benefits access for LIS, MSP, and SNAP. In each pilot project, the lead agencies are bringing together coalitions of aging, anti-hunger, and private sector agencies to find ways to streamline policies and procedures for these benefits in those states. The Center will use the resources, lessons learned, and outcomes of this initiative in its technical assistance provided to the MIPPA grantees to replicate the successes therein.

**Conclusion**

The funding provided by the 2009 and 2010 MIPPA grants has strengthened the capacity of the aging services network to improve access to benefits and made Medicare more
affordable for hundreds of thousands of low-income Medicare beneficiaries. MIPPA grants have also allowed states to become incubators of best practices on benefits outreach and enrollment, especially in the areas of partnerships and data-sharing. More importantly, the applications submitted for Part D Low-Income Subsidy and the Medicare Savings Programs helped hundreds of thousands of Medicare beneficiaries live healthier and independent lives and the nearly $2 billion in annual benefits created much needed economic activity in their communities.

For more information

To read more about MIPPA grantees’ successes and lessons learned, visit the Center online at: www.centerforbenefits.org.