Community Solutions:

Lessons Learned from the My Medicare Matters Low-Income Subsidy Demonstration Program

My Medicare Matters™

National Council on Aging

Mission

To improve the lives of older Americans

Core Values

- Social and economic justice
- Respect and caring for all
- Innovation
- Excellence and integrity

Core Competencies

COLLABORATIVE LEADERSHIP

- Creating and leading strategic alliances, coalitions, and multi-sector partnerships
- Organizing, mobilizing, and supporting nationwide "communities" of organizations and leaders

ADVOCACY

- Improving public policies by:
  - Combining service and advocacy
  - Being a national voice for older adults in greatest need and those who serve them

INNOVATION

- Fostering and diffusing innovations
- Making markets work better for older adults

NCOA
NATIONAL COUNCIL ON AGING

Social Impact

For all older adults, with special focus on those who are disadvantaged and/or vulnerable:

HEALTHY AGING

- Improved health and reduced disability

WORKFORCE DEVELOPMENT

- Increased participation in meaningful and rewarding work

CIVIC ENGAGEMENT

- Increased community service that enriches participants and is productive for society

ACCESS TO BENEFITS

- Increased access to public and private benefits and resources

LONG-TERM SERVICES AND SUPPORTS

- Enhanced capacity to live in communities with dignity, choice, and financial security

Who We Are

Founded in 1950, the National Council on Aging (NCOA) is a national organization with 3,700 members and a national network of more than 14,000 organizations and leaders. Our members include senior centers, area agencies on aging, adult day service centers, faith-based service organizations, senior housing facilities, employment services, consumer groups, and leaders from academia, business, and labor.

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This report is published by the National Council on Aging. Additional copies can be found at *www.MyMedicareCommunity.org*. A limited number of printed copies may be obtained by writing to My Medicare Matters at: NCOA, 1901 L Street, NW, 4th Floor, Washington, DC 20036.

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Executive Summary

Upon the conclusion of the Initial Enrollment Period for Medicare Part D in May 2006, millions of beneficiaries had new drug coverage through Medicare. However, despite unprecedented outreach and enrollment efforts by federal and state agencies, as well as local, community-based organizations, significant challenges remained in terms of getting coverage for the most vulnerable beneficiaries—those with limited incomes and resources.

In late 2006, My Medicare Matters determined that there was an opportunity to seek new learnings about how to maximize the number of eligible people who are enrolled in the Medicare Part D Extra Help/Low-Income Subsidy (LIS, or Extra Help). NCOA conducted a competitive grant program, selecting and funding local and state organizations whose ideas offered the most promise for developing and implementing innovative, cost effective and potentially replicable strategies for finding and enrolling qualifying Medicare beneficiaries with limited incomes and resources in the LIS and other related benefits.

Grantees achieved overwhelming success in their drive to find and assist beneficiaries with limited means in applying for the LIS and other related benefits. While the original enrollment goal for all grantees was to help a total of 9,000 people apply for LIS, they far surpassed that target, submitting LIS applications for more than 40,000 likely eligible beneficiaries during the 15-month grant period. The grantees' work also provided important learnings about the benefits outreach and enrollment process at the state and community levels, which are detailed in this report and in an accompanying electronic toolkit for community-based organizations, which can be found on My Medicare Community (*www.MyMedicareCommunity.org*), NCOA's online community for professionals and volunteers who work with people with Medicare.

While the initial years of Part D implementation have largely been successful in getting needed prescription drug coverage to millions of people with Medicare, there is still a long road ahead when it comes to LIS outreach and enrollment. The outcomes of efforts like this demonstration program and the learnings that it provides can help to bring us ever closer to fulfilling the promise of the LIS and other important benefits for those who need them most.

Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) was designed to enhance the Medicare program with the important addition of prescription drug coverage. People with Medicare, for whom therapeutic needs are greater than the general population, now have broader access to the prescription drugs they need through prescription drug plans and other health plans available under the Medicare Prescription Drug Coverage (also known as Medicare Part D).

Beneficiaries with limited incomes and resources are eligible to receive assistance through the Extra Help/Low Income Subsidy (LIS, or Extra Help), which can greatly reduce or, in some cases, eliminate the beneficiary out-of-pocket costs associated with Medicare prescription drug coverage. The monetary value of the Extra Help to a low-income beneficiary was estimated by the Centers for Medicare & Medicaid Services (CMS) to be nearly $3700 in 2008.[1]

Upon the conclusion of the Initial Enrollment Period for Medicare Part D in May 2006, millions of beneficiaries had new drug coverage through Medicare Part D. However, despite unprecedented outreach and enrollment efforts by federal and state agencies, as well as local, community-based organizations, significant challenges remained in terms of getting coverage for the most vulnerable beneficiaries—those with limited incomes and resources. In June 2006, CMS stated that, of the 4.4 million people who did not have drug coverage through Medicare or creditable coverage through an employer or other source, about three-fourths (over 3.2 million) were likely eligible for the LIS.[2] An additional unknown number of beneficiaries who were likely eligible for LIS, but not yet enrolled, were already in Part D plans. Thus, there remained a significant challenge to finding and assisting those who needed the LIS most.

My Medicare Matters

Led by the National Council on Aging (NCOA) and the Access to Benefits Coalition (ABC), with the support of AstraZeneca Pharmaceuticals, LP, My Medicare Matters is a comprehensive national educational program that seeks to achieve two results:

- Maximize the number of people who are “informed consumers” of Medicare Part D and who are able to take appropriate next steps, and

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1 Centers for Medicare & Medicaid Services press release, “Medicare Part D Plan Premiums for 2008 Show Continued Impact of Strong Competition,” August 13, 2007. *http://www.cms.hhs.gov/apps/files/PressReleasePartDBenchmark.pdf*

2 Centers for Medicare & Medicaid Services press release, “Over 28 Million People with Medicare Now Receiving Prescription Drug Coverage,” June 14, 2006.

- Maximize the number of eligible people who enroll in the Medicare Part D Extra Help/Low-Income Subsidy.

The My Medicare Matters program was created in fall 2005 to help people with Medicare, their families, friends and caregivers—and the community-based organizations that assist them—navigate the overwhelming array of prescription drug plans available through the Medicare Prescription Drug Program. During the Initial Enrollment Period for Part D from November 2005 through May 2006, My Medicare Matters included a community-based education and outreach campaign that ran in 40 metropolitan areas in 27 states. The program provided more than 210,000 people with one-on-one assistance at local community events to understand Part D and make the right choice for their health and financial situation. In addition, My Medicare Matters hosts two Web sites that provide easy-to-understand educational information about Part D; one site is in English (*MyMedicareMatters.org*), the other in Spanish (*MiMedicareImporta.org*). More information about My Medicare Matters can be found in the report entitled *Harnessing the Power of Partnerships: Lessons Learned from My Medicare Matters* (*https://www.ncoa.org/Downloads/PowerOfPartnershipsReport.pdf*).

The My Medicare Matters Low-Income Subsidy Demonstration

At the conclusion of the Part D Initial Enrollment Period in 2006, My Medicare Matters continued to educate Medicare beneficiaries and seek new learnings about how to maximize the number of eligible people who are enrolled in the Medicare Part D Extra Help. As a result, in late 2006, NCOA announced the availability of grant funds for local and state organizations to develop and implement innovative, cost effective and potentially replicable strategies for finding and enrolling likely eligible Medicare beneficiaries with limited incomes and resources in the LIS and other related benefits.[3]

Grants were initially awarded to nine local and state organizations with funding ranging from $20,849 to $100,000, based on an agency's enrollment goals.[4] Table 1 presents an overview of the demonstration grantees by setting and agency type. Grantee activities ran from February 2007 through March 2008.

Several grantees were able to effectively utilize AmeriCorps*VISTAs to support their efforts under this grant. Founded as Volunteers in Service to America in 1965 and incorporated into the AmeriCorps network of programs in 1993, AmeriCorps*VISTA has been on the front lines in the fight against poverty in America for more than 40 years. AmeriCorps*VISTAs made sizeable contributions to this project in several areas including partnership support, creating awareness of the LIS benefit throughout the community, and in supporting outreach and enrollment initiatives.

Grantees achieved overwhelming success in their drive to find vulnerable beneficiaries and help them apply for the LIS, the Medicare Savings Programs (MSP)[5] and other related benefits. While the original enrollment goal for all grantees was to help a total of 9,000 people apply for LIS, the grantees far surpassed that target, submitting LIS applications for more than 40,000 likely eligible beneficiaries during the 15-month grant period.[6] Their work also provided important learnings on the benefits outreach and enrollment process at the state and community levels. These learnings will be outlined in greater detail later in this report.

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[3] Because enrollment in other important public benefits such as Medicaid, Supplemental Security Income (SSI), and the Medicare Savings Programs (MSP) also causes a person to be "deemed" automatically eligible for LIS, the decision was made early on to have applications submitted for those programs also count toward grantees' overall enrollment goals.

[4] One of the original grantees dropped out in the early stages of the funding period and is therefore not included in this report. Ultimately, two additional awards were made in fall 2007, but results from those projects are not reported here due to their later start.

[5] The Medicare Savings Programs, also known as QMB (Qualified Medicare Beneficiary), SLMB (Specified Low-Income Medicare Beneficiary), and QI (Qualifying Individual), help beneficiaries with limited incomes and resources to pay their Medicare Part B premiums, and in some cases, other Medicare cost-sharing.

[6] This total enrollment figure includes 13,000 beneficiaries who were enrolled in LIS thanks to a major state legislative change advocated for by one of our grantees. This change facilitated the enrollment of the state's State Pharmacy Assistance Program members into the Medicare Savings Programs, making them automatically eligible for LIS.

TABLE 1 My Medicare Matters Grantees by Setting and Agency Type

3 in Large Rural States

- 1 legal services agency
- 2 non-profit coalitions

1 in a Small Metropolitan Community

- Area Agency on Aging

4 in Large Metropolitan Communities

- 3 Area Agencies on Aging
- 1 non-profit service agency

2 in Rural Communities

- Area Agency on Aging
- Community-based organization

Methodology

Assessment of grantee activity and success consisted of two main components: case studies of each agency and a cost data analysis. The overall approach to the evaluation was to measure the outcomes (number of LIS and other related benefits applications submitted and the cost per application submitted) and understand what processes and factors influenced the success of activities undertaken by grantees.[7] Given the burden of detailed cost data collection, the diversity in the grantee organizations, and the relatively small number of grantees in this project, it is difficult to draw broad conclusions on the effectiveness of any particular activity or strategy. In addition, nearly all grantees used multiple outreach and identification strategies, which further complicated efforts to parse out costs by specific type of activity. However, the evaluation does provide an understanding of how a grantee's "bundle" of activities fared, the context within which these activities took place, and learnings from grantee activities that could be instructive to other organizations interested in undertaking this work.

NCOA designed the evaluation study in close collaboration with L&M Policy Research, a health policy research firm, which also carried out the research and analysis for this study. To gain a comprehensive understanding of the grantees' operations and capabilities, the project team conducted three main data collection activities:

- **Preliminary site visits:** The project team met with grantee staff, including those managing and directly implementing the outreach and enrollment activities, as well as relevant financial, information technology, and database staff with knowledge of the mechanics of data collection and finances. This on-site visit provided the team with a detailed understanding of the agency's infrastructure and capacity, processes, organization, outreach plans, and enrollment strategies.
- **Interim Data Collection:** Cost data was collected monthly (more below), and the project team participated in monthly, NCOA-led calls with grantees to obtain updates on grantee activities, changes in strategies, successes, and obstacles.
- **Second Round Interviews:** Telephone interviews were conducted near the end of the grant period with each grantee. In these interviews, grantees described changes in their outreach strategies over the course of the grant period, lessons learned, and successful practices. All interviews with grantees were based on an open-ended protocol.

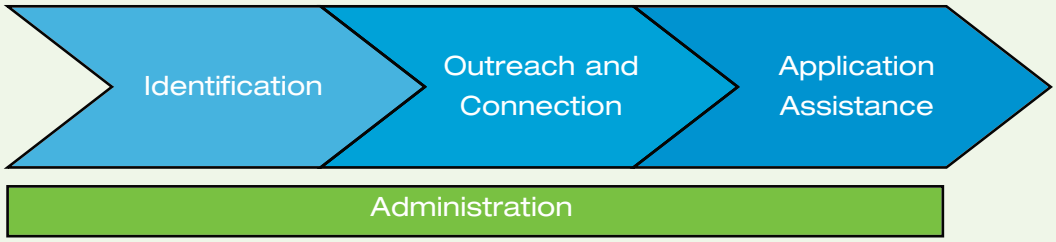
[7] Costs are calculated per LIS (or other related benefit) application submitted, rather than per actual "enrollment" because the Social Security Administration only notifies beneficiaries of their approval/denial for LIS. Verification of actual enrollment in LIS or related benefits was outside the purview of these grants.

Grantees reported their cost data monthly via an on-line survey tool to help the project team assess the cost per application submitted. The survey template helped grantees report their direct and indirect costs. This included all costs associated with their LIS outreach and enrollment activity, not just those covered by the grant the organization had received through the My Medicare Matters demonstration program. Grantees reported their labor expenditures by providing hours per month spent on identification, outreach, connection, enrollment, and administration, as well as salary and agency fringe benefit rate information. Other data collected included costs for travel, telephone, print materials and postage, equipment, or other incidental costs associated with their outreach and enrollment work.

A 20 percent overhead rate was assumed and added to both labor and other costs to facilitate the cost-accounting needed to conduct the evaluation, since grantees do not typically calculate overhead. The overhead rate is taken from the Access to Benefits Coalition 2006 report entitled *Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes* in which the cost infrastructure of similar types of community agencies was assessed and calculated to be 20 percent of salaries and total costs, on average. Figure 1 describes in more detail the stages of the outreach and enrollment process used to collect these cost data.

FIGURE 1 In Depth—The Outreach and Enrollment Process

For the cost analysis, we asked each grantee to break their costs (staff time and other direct costs) by stage of the enrollment process. In this box, we define these stages, and outline different types of activities used by grantees during these stages.



Identification: Process for finding qualified leads within the target population—in this case, Medicare beneficiaries not deemed to be automatically eligible for the LIS—through activities such as data mining, Census block analysis, culling client lists, working with other agencies to develop lists. Activities included:

- Developing and using short pre-screening checklists to better identify beneficiaries most likely to qualify

FIGURE 1 In Depth—The Outreach and Enrollment Process (Continued)

- Reviewing internal client lists for potential eligibles
- Geomapping using census and income data to identify neighborhood blocks where those likely eligible may live
- Screening beneficiaries enrolled in other assistance programs (e.g., working with other agencies conferring benefits to likely eligibles) or who come to their agency for other needs
- Utilizing CMS data by county and zip code to determine areas predicted to have highest concentrations of LIS eligibles to plan where to conduct educational and enrollment events

Outreach and connection: Activity related to educating potential LIS-eligible people about the benefit, persuading them to apply for the LIS and establishing a relationship of trust between client and intermediary. This includes: planning and administering outreach efforts; training and managing volunteers; media efforts; translation services; and partnership development and management; increasing awareness, educating potential eligibles.

- Use of media
  - Developing LIS-specific television/radio public service announcements, and appearing on well known and respected local radio and television stations
  - Advertising in local newspapers and directories
  - Advertising on billboards and bus benchbacks
- Presentations and Other Educational Events
  - Conducting education and enrollment sessions where low-income seniors gather, such as churches or low-income senior housing complexes
  - Using health fairs or study circles (small monthly discussion groups on health-related topics) to raise awareness of the LIS
- Tailored Print Materials
  - Placing advertisements such as billboards, flyers, or posters in areas likely frequented by eligible beneficiaries, such as laundromats, groceries, pharmacies and in certain bus routes (benchback advertising)

FIGURE 1 In Depth—The Outreach and Enrollment Process (Continued)

- Using door hangers in order to catch people where they live
- Being sensitive to potential language differences by translating fliers into appropriate languages
- Developing simple messages that appeal to beneficiaries, taking into account education levels, cultural differences and language preferences

- Door-to-Door Outreach
  - Using geomapping to specifically target neighborhoods and even addresses where low-income beneficiaries may live
- Building and Fostering Partnerships in the Community
  - "We can't do it alone"—Building and developing partnerships with both traditional and non-traditional partners, and ethnic minority community organizations to expand identification and outreach activities to target populations

Application Assistance: Working with beneficiaries to complete and submit actual LIS applications, including filling in the blanks on a paper application, working with individuals to gather personal information needed to complete the application, entering information into the online applications, etc.

- Placing knowledgeable benefit and outreach specialists who are trusted in the community to counsel and enroll beneficiaries on LIS and other public benefits
- Providing one-on-one application assistance due to complexity of the LIS application (e.g., explaining the cash value of life insurance policy)

Administration: Any activities or costs associated with the administration of outreach and enrollment efforts, including staff time for fiscal management or administrative support.

Grantees reported the number of LIS (and other related benefits) applications completed and submitted each month. Calculating total costs using the information grantees reported each month and dividing by the number of applications submitted provided a cost per application figure. Grantees also reported the methods used to submit LIS applications—online (either through NCOA's BenefitsCheckUp® online Extra Help application or the Social Security Administration's Web site), on paper, or via auto-enrollment through other programs. They also reported the numbers of professionals they trained, the number of beneficiaries they educated, and the number of beneficiary counseling sessions completed.

Despite the thoroughness of the evaluation methodology, there were some limitations to our ability to fully assess the impact of these grant activities. For example, reporting requirements for tracking specific activities were deemed too burdensome for grantees to collect, so the study team relied on proxy measures or anecdotal evidence to determine whether activities were effective (e.g., large attendance at an event, perceived increases in telephone calls to the agency regarding LIS, outreach worker anecdotes from the field). There were also a number of limitations with the cost data collected, which primarily reflects the efforts of the grantees although statistics about applications submitted also include data from grantee partners. Some grantees also collected cost data from their partners. In light of these limitations, the cost data may either over- or under-estimate. However, these data are reflective of best available data. This in itself is an important learning, and we are grateful for the time each grantee spent sharing their experiences and reporting the macro-level cost and application assistance information to the team.

However, while there are limitations quantitatively, the qualitative findings from this demonstration are rich, yielding important lessons with regard to partnership development and management and other outreach strategies. These qualitative findings will be explored in greater depth later in this report.

Description of Grantees

AGENCY A

Organization type: Legal services agency

Geographic areas covered: Entire state

Targeted underserved populations: Rural beneficiaries, homebound beneficiaries, younger beneficiaries with disabilities, and beneficiaries with limited English proficiency

Identification strategies:

- Use of qualified contact lists to conduct mailings to undeemed individuals, beneficiaries with disabilities and Meals-on-Wheels participants.

Outreach & Connection strategies:

- Television commercials & print media to raise awareness of LIS and other benefits.
- Multi-purpose mailer with simple messaging.
- Callers from the state-wide toll-free number were routed to their local State Health Insurance Assistance Program (SHIP) where they received individualized counseling and enrollment support.

LIS application assistance:

- Callers from the state-wide toll-free number were routed to their local SHIP where they received individualized counseling and enrollment support.

Total cost per LIS applicant: **$2.16 ($5.54 adjusted) ****

Total LIS applications: **22,297 (9,055 adjusted)**

** During the course of the grant period, the state in which Agency A was located had a major state legislative change which facilitated the enrollment of its State Pharmacy Assistance Program members into the Medicare Savings Programs. This resulted in a significant increase in MSP—and consequently, LIS—enrollment during a particular month during the grant period. In the adjusted figures above, the study team replaced the actual enrollment figure from that month with an average of all other monthly reported application numbers in an attempt to estimate what the application numbers would have been for that month without the legislative change.

AGENCY B

Organization type: Non-profit coalition

Geographic areas covered: Entire state

Targeted underserved populations: Rural population with a specialized focus on Hispanic and African-American population (in two counties)

Identification strategies:

- Use of statewide benefit specialist network to identify those likely eligible for the LIS.

Outreach & Connection strategies:

- Group outreach and educational events in two counties.
- Partnership with other community-based organizations that could provide access to minority populations.
- Television commercials to raise awareness of LIS and other benefits.

LIS application assistance:

- On-site screening and application assistance at group events.
- Benefit specialists provided assistance to those wishing to apply for LIS or other benefits.

Total cost per LIS applicant: **$6.96**

Total LIS applications: **7,805**

AGENCY C

Organization type: Area agency on aging (AAA)

Geographic areas covered: Large metropolitan area & surrounding suburban counties

Targeted underserved populations: Younger beneficiaries with disabilities and beneficiaries with limited English proficiency

Identification strategies:

- Use of existing partner network to screen all clients for LIS.
- Utilized CMS data by county and zip code to determine areas predicted to have highest concentrations of LIS eligibles and plan where to conduct educational and enrollment events.

Outreach & Connection strategies:

- Identified new partners that could expand reach and visibility throughout community, including the local Department of Public Health, as well as community-based clinics and hospitals that provided services and prescription drugs to people with limited incomes.
- Educational and promotional materials.

LIS application assistance:

- All partners were able to assist individuals with enrollments by phone, in person and on-site at events.

Total cost per LIS applicant: **$25.30**

Total LIS applications: **5,421**

AGENCY D

Organization type: AAA/State Health Insurance Assistance Program (SHIP)

Geographic areas covered: Multi-county urban and rural region

Targeted underserved populations: Hispanic beneficiaries and other beneficiaries with limited English proficiency, beneficiaries with low-literacy and homebound beneficiaries

Identification strategies:

- Used Geographic Information System (GIS) technology fed by county data to determine areas predicted to have highest concentrations of LIS-eligible people.
- Use of existing partner network to screen all clients for LIS.

Outreach & Connection strategies:

- Promotoras (lay health educators) conducted door-to-door outreach in GIS identified communities. Reverse look-up technology was utilized to connect with homeowner prior to visit. This technology enabled the grantee to obtain detailed contact information for particular addresses.
- Group outreach and educational events.

LIS application assistance:

- Promotoras were equipped with laptops and Internet access that enabled them to enroll people in their homes.
- On-site screening and application assistance at group events.

Total cost per LIS applicant: **$86.01**

Total LIS applications: **1,249**

AGENCY E

Organization type: Community-based non-profit with focus on the Hispanic population

Geographic areas covered: Multi-county rural region

Targeted underserved populations: Rural, Hispanic beneficiaries

Identification strategies:

- Utilized CMS data by county and zip code to determine areas predicted to have highest concentrations of LIS eligibles and plan where to conduct educational and enrollment events.
- Use of existing partner network to screen all clients for LIS.

Outreach & Connection strategies:

- Use of advertising, Public Service Announcements (PSAs) and appearances on local radio shows, and bench-back advertising to raise awareness of LIS and other benefits.
- Promotoras provided education and assistance in the community.
- Group outreach and educational events with opportunities for individualized counseling.

LIS application assistance:

- Promotoras were equipped with laptops and Internet access that enabled them to enroll people in their homes.
- On-site screening and application assistance at group events.

Total cost per LIS applicant: **$175.40**

Total LIS applications: **925**

AGENCY F

Organization type: AAA/SHIP

Geographic areas covered: Multi-county urban region

Targeted underserved populations: Beneficiaries with limited English proficiency, younger beneficiaries with disabilities, beneficiaries with mental retardation or developmental disabilities

Identification strategies:

- Ensured all clients served by lead agency were screened for LIS.

Outreach & Connection strategies:

- Use of flyers translated into multiple languages.
- Outreach and education through programs that served seniors with limited incomes, such as Meals-on-Wheels and local food banks.
- Group outreach and educational events.
- Advertising in local newspapers.

LIS application assistance:

- Individualized counseling and application assistance over the phone or in person.

Total cost per LIS applicant: **$413.40**

Total LIS applications: **90**

AGENCY G

Organization type: Non-profit organization addressing health care access

Geographic areas covered: Large city & surrounding suburban counties

Targeted underserved populations: Homebound beneficiaries and younger beneficiaries with disabilities

Identification strategies:

- Utilized CMS data by county and zip code to determine areas predicted to have highest concentrations of LIS eligibles and plan where to conduct educational and enrollment events.
- Use of existing partner network to screen all clients for LIS.

Outreach & Connection strategies:

- Use of billboard advertising, radio Public Service Announcements (PSAs), television news segments and education of partner network to raise awareness of LIS and drive enrollment "traffic" to lead agency.
- Group outreach and educational events.

LIS application assistance:

- Individualized counseling and application assistance over the phone or in person.
- On-site screening and application assistance at group events.

Total cost per LIS applicant: **$137.31**

Total LIS applications: **1,209**

AGENCY H

Organization type: AAA/SHIP

Geographic areas covered: Large city & part of surrounding suburban county

Targeted underserved populations: African-American beneficiaries, Hispanic beneficiaries, Arab beneficiaries, Native American beneficiaries, Asian-American/Pacific Islander beneficiaries, homebound beneficiaries and younger beneficiaries with disabilities

Identification strategies:

- Use of existing partner network to screen all clients for LIS. Offered partners a fee of $75 for each pre-screened referral resulting in a successful LIS application submittal.
- Partner review of existing client lists to identify those likely to qualify for the LIS.
- Utilized CMS data by county and zip code to determine areas predicted to have highest concentrations of LIS eligibles and plan where to conduct educational and enrollment events.

Outreach & Connection strategies:

- Group outreach and educational events.
- Use of print media to raise awareness of LIS.
- Also reached out to programs that served seniors with limited incomes such as Meals-on-Wheels to promote LIS.

LIS application assistance:

- Partners conducted preliminary screening and then referred those who were likely LIS-eligible to enrollment center for application assistance.
- On-site screening and application assistance at group events.

Total cost per LIS applicant: **$79.95**

Total LIS applications: **1,057**

Environmental Challenges

Like other organizations engaged in this work, My Medicare Matters grantees faced a variety of barriers as they engaged in their LIS outreach and enrollment initiatives. For most grantees, the grant period ran from February 2007 through March 2008. With the "deeming" of those enrolled in Medicare, MSP, and SSI and the major push by federal state and local organizations to find and assist low-income beneficiaries during the Initial Enrollment Period[8], many of the easily identified and enrolled eligibles had been enrolled in 2006. This left the most underserved beneficiaries as our target population—people who are dispersed, difficult to reach for a variety of reasons, and/or reluctant to enroll in government programs. Organizations that had been working to enroll LIS-eligible beneficiaries since the inception of Part D were forced to re-tool outreach and enrollment strategies to target beneficiaries who were not drawn to the initial LIS outreach. Grantees also reported that beneficiaries, staff and partners alike were experiencing Part D fatigue with the numerous messages regarding Part D and the LIS in 2006 and early 2007.

Grantees' outreach and enrollment efforts were also challenged by "competition" from various sources. For example, some grantees were located in states with highly-regarded state pharmacy assistance programs (SPAPs) that were often more familiar to beneficiaries and sometimes were more generous than the LIS. Even in cases where the SPAP was not as robust a benefit as LIS, many individuals did not want to give up a program to which they were accustomed, despite potential access to a better set of benefits if they were to qualify for the LIS.

Along similar lines, clients enrolled in other programs, such as Food Stamps or housing assistance that could be affected by LIS enrollment, were often reluctant to apply for the Extra Help fearing the loss or reduction of those vital benefits. Finally, in areas with active marketing of Medicare Advantage plans, some grantees reported that their LIS messages were overshadowed and hampered by these marketing activities—particularly when low-income beneficiaries in their area had been (or knew others who had been) negatively impacted by these aggressive marketing practices.

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[8] The Medicare Part D Initial Enrollment Period ran from November 15, 2005 through May 15, 2006. However, CMS has authorized a continuous enrollment period for those eligible for LIS through December 31, 2008.

Key Findings and Lessons Learned

The purpose of this evaluation was to both capture how well grantees were able to identify and assist eligible beneficiaries with applying for the LIS program (measured by cost and application assistance metrics), and characterize factors associated with effective outreach and enrollment strategies. The eight organizations that are the focus of this evaluation report began the grant period with varying knowledge levels about the LIS and differing approaches to reaching and assisting their target populations. They also were starting from different points in the outreach process—some organizations were supplementing an existing strategy while others were starting from the beginning. The grantee organizations were also geographically diverse, serving different kinds of communities and utilizing an array of different outreach and enrollment approaches. Not surprisingly, results from these efforts varied widely, often driven by approaches and tactics each grantee used as well as the skill, effectiveness, and resources devoted to these efforts by each organization.

However, there were commonalities across the grantees, particularly in how the outreach and enrollment activities were managed. We found that each of the grantees could be characterized by one of the following types of management structure.

- **Centralized outreach:** In this model, the grantee primarily employed in-house staff to conduct their own outreach and enrollment activities. Partnerships were used only in a very limited fashion, typically to gain access to a segment of the target population. Grantee staff then either worked directly with or provided information to potentially eligible beneficiaries through partner staff (e.g., senior housing managers, Meals-on-Wheels staff).
- **Decentralized outreach with a high-intensity, close-knit partnership network:** In this model, the grantee functioned as the lead agency for local partners, which operated almost like satellite-type offices located in the communities they served. This model typically leveraged an established partnership network. The grantee sometimes provided in-depth training, technical assistance, and/or significant financial or in-kind support to partners, and often required partner agencies to report outreach results.
- **Decentralized outreach with a low-intensity, loose-knit partnership network:** In this management model, the grantee organization managed the enrollment function and served primarily as a training and resource center for partners, often providing one-time training and education sessions to many local organizations. The partnership network was in its preliminary stages of development and was characterized by numerous partner organizations with limited resources to dedicate to LIS outreach and enrollment.

These three management approaches offer an organizing framework under which we were able to observe patterns of relative success and identify opportunities and obstacles. Many of the grantees conducted similar activities or undertook similar approaches, and it was the management and structure of the grant activities that seemed to be a defining characteristic in how well certain approaches were implemented. There was notable variation within each category, but it is instructive to present the findings sorted in this way to help map this grant effort as a template for future efforts. Organizations conducting outreach and enrollment in the future to people with limited income and resources will likely fall into one of these categories, so understanding the opportunities and challenges inherent in each is important.

It should be noted that with only eight grantees, all hailing from such different communities and starting from differing bases of expertise, it is difficult to make robust generalizations on findings. However, it is instructive to organize findings by these management categories since they cut across geography, populations served, and resource levels.

Cost Findings

Cost figures and the number of LIS or other related benefit applications varied widely across grantees due to environmental, geographical, and managerial differences. Costs per enrollee ranged from $2.16 to $413.40 (Table 2), and the total number of applications submitted across all grantees was 40,053 (adjusted to 26,811).[9] While the number of applications submitted and costs per application varied, there were some broad similarities in costs per enrollee and total enrollment numbers based on management model type. Generally, grantees falling under the decentralized, high partner involvement approach had higher numbers of applications submitted and lower costs-per-application, followed by grantees utilizing a decentralized but low partner involvement approach and the centralized direct outreach approach, respectively. It should be noted that cost data is representative of the lead agency, while the application submission numbers come from the lead agency and its partners.

[9] This parenthetical figure is adjusted to account for the large number of enrollments in one particular month for one grantee due to the state legislative change reported earlier.

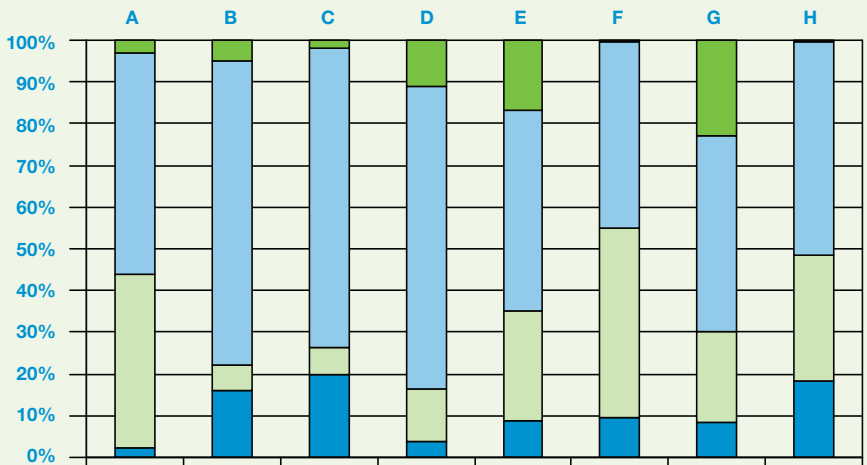
TABLE 2 Summary of Costs and Application Submissions by Management Model

Management Model	Agency	Cost per Applicant	Total Application Submissions
Decentralized Outreach (High Partner Engagement)	A	$2.16	22,297
	A (adjusted)	$5.54	9,055
	B	$6.96	7,805
	C	$25.30	5,421
Decentralized Outreach (Low Partner Engagement)	G	$137.31	1,209
	H	$79.95	1,057
Centralized Direct Outreach	D	$86.01	1,249
	E	$175.40	925
	F	$413.40	90

Figure 2, below, presents the percentage distribution of hours spent by each grantee on the different phases of the enrollment process. While it is informative to report how grantees spent their time, it is important to consider the different factors driving the variation, such as which outreach and enrollment strategies were focused on, and the efficiency with which certain activities were conducted. In addition, in an organization new to LIS or other public benefits outreach, completing and filing applications might take more time than it would in an organization already fluent in the program and process. Also, organizations developing or maintaining networks of partners might spend proportionately greater time on administration than those with fewer partners or more established partner networks. Finally, some grantees were serving communities in which relatively few eligibles remain (under 500). Finding these "needles in a haystack" could alter the distribution of hours spent compared to a situation in which a grantee was reaching out to a population where eligibles were easier to locate.

It is with caution, therefore, that conclusions or inferences be drawn from these numbers. Capturing the level of detail required to parse out which factors are the likely drivers would have required asking grantees to calculate time spent at a micro-level, such as minutes or hours per application. This would have been prohibitively burdensome, and for many grantees, could have resulted

FIGURE 2 Percentage of time spent, by enrollment process phase



	A	B	C	D	E	F	G	H
Applications Cost	22,297 $2.16	7,805 $6.96	5,421 $25.30	1,249 $86.01	925 $175.40	90 $413.40	1,209 $137.31	1,057 $79.95
Identification	2.90%	4.96%	2.06%	11.13%	16.68%	0.54%	22.79%	0.32%
Outreach and Connection	53.06%	72.85%	71.60%	72.35%	48.36%	44.49%	46.87%	51.13%
Enrollment	41.61%	6.20%	6.67%	12.83%	26.07%	45.40%	21.85%	30.35%
Administration	2.43%	16.00%	19.68%	3.69%	8.89%	9.58%	8.49%	18.20%

in as much time spent recording and reporting data as conducting the outreach and enrollment, which was not the intent of this demonstration program. During evaluation interviews with the grantees, efforts were made to uncover which factors were at play for a particular grantee.

DECENTRALIZED OUTREACH, HIGH PARTNER ENGAGEMENT

Grantees in this category typically engaged in direct enrollment assistance with potential eligibles identified and referred through in-field partners, from local media campaigns and community presentations. Costs per enrollment for these grantees ranged from $2 to $25, with the range shifting to $6 to $25 when excluding the enrollment impact of the legislative intervention in one of our grantee states, as described earlier. The number of applications generated by these grantees ranged from 5,421 to 22,297 individuals, and ranged from 5,421 to 9,055 when eliminating enrollments driven by legislative intervention.

Staff and partners associated with these grantees had experience conducting Part D and/or LIS outreach and enrollment and a strong sense of what was working in their respective communities. Therefore, they required very little training before beginning to conduct their outreach and enrollment activities. These grantees were also able to build on what was already working in their communities.

The grantee with the lowest cost-per-application submitted was aided in part by significant legislative changes, but also had developed a successful local media campaign that complemented the efforts of an already proactive and trained outreach and enrollment staff who were well known in the community. Two of the three grantees in this group spent relatively more time on administration, typically managing and interacting with their networks of partners to ensure that outreach and enrollment activities were running smoothly.

DECENTRALIZED OUTREACH, LOW PARTNER ENGAGEMENT

Grantees in this category focused almost exclusively on developing and maintaining a network of partners to help identify and refer beneficiaries on behalf of the lead agency, and spent the remainder of their time conducting community presentations, taking advantage of local, earned media opportunities and participating in local events such as health fairs and other community events. The costs per enrollment ranged from $80 to $137, with the number of applications filed ranging from 1,057 to 1,209.

This group differs from grantees using a decentralized outreach, high partner engagement model because staff generally had to start from scratch, building relationships with partner organizations, training the partners and then maintaining that partner network. This process was labor intensive and often did not yield as many qualified leads as grantees had hoped. They spent approximately 61 percent of their time developing partnerships and working with these new partners to identify lists of eligible beneficiaries. Despite initial enthusiasm, partners were often unable to dedicate enough of their time to conduct the necessary outreach to generate leads or enroll beneficiaries. These organizations on average spent 21 percent of their time actively assisting beneficiaries with applications, which were often generated through community events and required lengthy follow-up. While categorized separately from the decentralized, highly-engaged partner group, one could also view this group of grantees as early versions of the other group. Over time, and with careful cultivation of their partner networks, the efforts of those in this category could yield lower costs-per-application submitted.

CENTRALIZED OUTREACH

Grantees in this category generally conducted a combination of presentations, educational sessions, community-based events, some local media activities, and one-on-one application assistance. Among this group of grantees, the cost per application submitted ranged widely from $86 to $413, with the total number of applications submitted also varying significantly from 90 to 1,249. With only

one exception, grantee staff had to be trained on Part D and LIS prior to beginning their work, although they were all trusted neighborhood sources with experience interacting with the target population. One significant challenge faced by the grantee with the $413 cost per application submitted was a very small remaining population of eligible beneficiaries in their service area. This meant they had to spend much more of their time and resources on finding and connecting with these beneficiaries, resulting in lower numbers of applications completed overall.

Lessons Learned

In addition to the numbers above, the site visits and additional interviews with grantees revealed several overarching learnings associated with outreach and enrollment approaches and activities, and certain themes also emerged from grantees' experiences. These "lessons learned" are presented below. More detail about these lessons, including advice from the grantees using particular approaches, can be found in an electronic toolkit for community-based organizations on My Medicare Community (*www.MyMedicareCommunity.org*), NCOA's online community for professionals and volunteers who work with people with Medicare.

PARTNERSHIPS

The most successful partnerships leverage the strengths of partners, and are realistic of time and resource constraints.

Effective partnerships are elemental to enrollment success and lower cost per application submitted. Nearly all grantees made use of different types of partnerships to enhance their outreach and enrollment activities. These ranged from more passive partners, who may have simply distributed LIS flyers to clients; reactive partners, who made referrals to the grantee agency if they came into contact with someone who might be eligible; and proactive partners, who actively conducted outreach to the community to screen and refer or undertake the full enrollment process.

In many cases, our grantees found that when it came to building partnership networks, depth was often more important than breadth. That is, working with a few well-chosen, engaged partners was often more successful than spending time and resources developing and then managing a larger network of well-intended partners who were only peripherally engaged. Not surprisingly, partnerships were most effective with organizations that had both buy-in from upper-level management and staff time to dedicate to the grant effort. The lowest costs per application submitted were among those grantees in the decentralized, close-knit partnership group. Grantees in this group were able to extend their reach into numerous communities as a result of this partner network; the networks were comprised of partners who had dedicated time to work on these outreach and enrollment activities,

were familiar with LIS and Medicare, and had experience working with the potentially eligible population. Being able to fund partners—whether up-front funding or a fee per application submitted—was also found to be helpful in garnering support and "buy-in" from partners.

Along similar lines, matching partner expertise to relevant tasks or roles was also critical. Partners added the most value when they contributed the skills that they were best positioned to offer. For example, agencies already working within a community doing LIS or other public benefit enrollments were natural, strong partners for our grantees. Other partners, with large client bases, but untrained in public benefits outreach and enrollment (or with limited time and resources for the initiative), served as good referral sources for likely eligible beneficiaries. They were also useful conduits for flyers and other written materials about LIS created by grantees.

Finally, process mattered when it came to developing partnerships. Just as important as finding the right partners was setting up a referral process with that partner that worked for both agencies and was as seamless as possible for clients. This was especially true when partners were not going to enroll beneficiaries but were simply going to refer clients to an enrollment center. Would a partner simply hand out flyers? Or could they commit to something more—such as pre-screening clients for eligibility and collecting names and contact information of those likely eligible to pass along to the enrollment center?

All of this points to the importance of preparation before forging new partnerships for benefits outreach and enrollment work. This preparation includes:

- **Determining what your agency's role is going to be:** Will you serve as an enrollment center? As a trainer for other partners who will provide enrollment assistance? Something else? What level of support will be required for your partner network?
- **Determining what you need partners to do:** Do you need organizations that can serve as enrollment centers? Do you need help with reaching out to certain target populations (e.g., younger beneficiaries with disabilities, beneficiaries in certain racial/ethnic minority groups, or caregivers)? Do you need assistance with media work?
- **Determining what your reporting requirements are for partners:** What information do you need partners to provide to you for reporting purposes? Do their internal systems support the collection of this type of data? If not, what procedures will need to be put into place to support the reporting requirement?
- **Community mapping:** Determine who the right partners are in your community. Which organizations have good connections to your target population(s)? Do you have an existing partner network that you can tap into for this work?

- **Interviewing your partners:** What are their strengths? How do those strengths fit with what you need? Do they have buy-in—both from leaders in the organization and from the front-line staff who will be doing the work? If they are not going to do enrollment, what referral process will be set up between your two organizations? What tools will your partners require in order to accomplish their designated tasks? Can they deliver the desired results within your required timeframes? Can they commit to your reporting requirements?

TAILORED OUTREACH

Successful outreach strategies are highly localized.

What works in one location may not work in another because of the scope of organization's reach, size of population targeted, and social and cultural differences among populations. In areas where church attendance was high, especially in communities with largely African-American populations, presentations to church groups and advertisements in church bulletins were found to be useful. In addition, producing materials in languages spoken prolifically in target areas was also often helpful, as was maintaining bilingual or multilingual staff to assist those who might respond to flyers produced in languages other than English. For example, one grantee utilized Geographic Information Systems (GIS) technology to target outreach efforts in predominantly Spanish-speaking communities. Through the use of promotoras (lay health educators who were fluent in Spanish), they were able to successfully connect with beneficiaries.

ROLE OF PRESENTATIONS

It's not just the content of the presentation, but what you do during and afterwards that can generate enrollments.

While large group presentations represented an opportunity to raise awareness about LIS and related topics, they did not yield many enrollments among grantees. Applications handed out were seldom returned, so grantees were very eager to "close the deal" on site. Yet beneficiaries were typically unwilling to discuss private matters in a public setting, and often did not have the information they needed with them to complete the application. Several grantees did note that having a private area for screening and enrollment that was behind a screen or in a corner often encouraged people to be more forthcoming. Group presentations also offered opportunities to conduct quick screens of individuals or collect contact information for future follow-up.

MAXIMIZE TRUST

Trusted staff and personalized enrollment assistance are key to 'closing the deal.'

Establishing rapport and trust is crucial to completing enrollments. Many grantees reported that it would often take multiple contacts with an individual, including reaching out through a relative, just to begin the screening process. In addition, in many of the communities represented by the grantees, seniors are aggressively targeted by Part D and other marketing efforts and wary of anyone perceived as selling something. Seniors also have been well-educated to tightly guard their financial and personal information, important guidance for many reasons.

However, personal information is necessary to complete an LIS application. Grantees often spoke of the balancing act between making someone feel comfortable and not asking too many personal questions and ensuring that enough personal data was captured to complete an application. This was a major concern because experience has shown that when an application was simply left with a beneficiary to complete, the process would often end without the application being submitted.

Grantees noted that trustworthiness can be demonstrated and a rapport built by having repeated, purposeful contact with beneficiaries or helping them with other social services or concerns. Also, several grantees were able to use logos of trusted and known organizations on their outreach materials within the community to provide further reassurance.

GEOGRAPHIC TARGETING

Supplementing what you already know about your population with geographic and demographic data can help target your outreach efforts and maximize efficiency.

Organizations engaged in the kind of benefits outreach and enrollment work our grantees were undertaking want to optimize their in-person efforts. Because one-on-one personalized assistance, which was repeatedly reported as an effective strategy to getting completed applications, was also the most labor-intensive approach, tools that can help outreach workers pinpoint 'eligible-rich' neighborhoods or zip codes is key. However, as the population of eligible beneficiaries decreases, a neighborhood-level approach may be too broad.

One technique used to identify potential eligibles was the GIS technology to map likely areas in which to conduct outreach and enrollment efforts. One grantee that was part of county government worked with county-level tax appraisal data and 2000 census data to predict where LIS eligibles resided in the community. The agency then conducted a follow-up door-to-door survey to validate that the local data would be a good predictor of where LIS eligibles resided. This step allowed the agency to concentrate its resources in areas where there was a high likelihood of potential eligible beneficiaries.

Ultimately, the agency found that the data lacked sufficient detail to reliably predict the location of eligible persons. For example, the data reflected owners who were deceased or property where the potentially eligible beneficiary did not actually reside. Also, the use of this data was not able to pinpoint where likely eligible beneficiaries who were not property owners might live. For GIS technology to be an effective tool in identifying the desired population, additional datasets that more accurately predict eligibility for a specific benefit would need to be used (such as other survey data, income-related databases, etc.).

Geographically solid demographic information at the outset of an outreach effort proved beneficial for early strategizing for all grantees. Since 2006 CMS has produced data annually at the state, county, and zip-code level which "include(s) Part D-eligible Medicare beneficiaries who 1) are not currently receiving prescription drug coverage and 2) may be eligible for extra help based on the median income of where they live."[10] Local and state agencies have been able to use this data effectively to target their LIS outreach and enrollment efforts.

MEDIA

Targeting media efforts is critical to reaching your target population.

Broad-based media efforts were generally ineffective for reaching low-income beneficiaries because they attracted too many people who were not likely eligible for LIS (or MSP), and who simply wanted Part D plan advice. But properly targeted television and radio appearances and PSAs showed promise in reaching low-income beneficiaries, with grantees observing spikes in telephone calls after such spots ran. Televised public service announcements or appearances on channels with a high level of senior viewership were reported by grantees as being successful. More specifically, earned media (news stories and coverage) received more attention and generated more calls from likely eligible beneficiaries than unearned media (paid advertising). For example, during the month following a local television news interview of one grantee's staff member, the grantee reported an 80 percent increase in the number of LIS (or other related benefit) applications completed and submitted. However, none of the grantees consistently tracked the source of contacts, so effectiveness of individual activities was difficult to quantify.

[10] *http://www.cms.hhs.gov/Partnerships/Toolkits/itemdetail.asp?itemID=CMS1188820*

TECHNOLOGY AND AUTOMATION

A small, up-front investment in automating application data can yield rich information to help refine and streamline outreach.

Enrollment in Part D and LIS has been greatly facilitated by the online tools developed by CMS, SSA, and other organizations. Incorporating those technologies into outreach and enrollment strategies can not only save time in the long run by streamlining processes, but can also generate rich data that can be analyzed to monitor and evaluate activities. Using an automated system for screening and enrollment provides rich and detailed data that can help you analyze your practices and be more efficient and cost effective.

My Medicare Matters grantees were provided free access to an online LIS screening and enrollment service developed by NCOA (BenefitsCheckUp.org®) that allowed them to submit LIS applications directly to the Social Security Administration. This service was helpful in facilitating remote enrollment events. (Through BenefitsCheckUp®, grantees also had the capability to screen beneficiaries for multiple benefit programs. Oftentimes beneficiaries that were identified as being eligible for the LIS were likely to qualify for other benefit programs as well.) Grantee staff were able to take laptops on site and start or complete enrollments with beneficiaries who had come for an event or presentation, which meant they did not have to come into the office to complete the application. In addition, this tool enabled grantees to track their application numbers and other statistics about the beneficiaries they assisted and the activities they conducted.

Conclusion

The question of which strategies work (or don't work) when it comes to identifying people with limited incomes and resources and helping them enroll in public and private benefits has challenged government agencies and nonprofit organizations alike for decades. The advent of Medicare Part D and the Extra Help/Low-Income Subsidy has offered us new opportunities for improving on those strategies and for providing much-needed assistance to people in need. However, even after the flurry of LIS outreach and enrollment activity that marked the Part D Initial Enrollment Period and the first two years of Part D, millions of beneficiaries with limited means have yet to be enrolled in this valuable benefit.

The My Medicare Matters LIS demonstration program, which provided grants to local organizations in 2007 and 2008 to find and assist qualifying Medicare beneficiaries with limited incomes and resources with applying for the LIS and other related benefits, represented a "living laboratory" for testing innovative benefits outreach and enrollment strategies. It provided experiential data for refining previously used tactics, and for learning from new initiatives.

Based on the demonstration program, this evaluation study shows that personalized, one-on-one assistance is one of the keys to enrollment success when it comes to public benefits. But while many different kinds of identification and outreach strategies—partnerships, media and advertising, geo-mapping, and more—can be effective in helping underserved beneficiaries to access that much-needed one-on-one help, the "devil is in the details" in terms of how all of these strategies are implemented and managed, particularly at the local level. As resources devoted to LIS outreach and enrollment efforts become even scarcer, the continuous learning that programs like this demonstration can offer to the field becomes even more critical for both the public and private sectors.

Two elements are most important when it comes to continuing this valuable learning process about benefits outreach and enrollment. First is a commitment to collecting the data needed to contribute to learnings in this area. Staff at community organizations like the My Medicare Matters grantees are dedicated to helping Medicare beneficiaries gain access to a variety of services and benefits available to them, including LIS, the Medicare Savings Programs, Food Stamps, and more. Typically, these organizations have multiple funding streams, which means that they also have different reporting requirements and have to collect different data elements for each funder.

However, these community-based organizations are not research-oriented agencies and therefore do not always have the internal expertise or infrastructure to support collecting data from partners or even reporting at levels of detail ideal for evaluation purposes. Further influencing their effectiveness is the fact that many funders do not include significant data collection and evaluation dollars into grants. Commitment to improved data collection must come from both funders and community-

based organizations alike. Funders must commit to augmenting grants with enough funding to make more rigorous evaluation possible, being flexible enough to work with grantees to develop data elements that are useful to both funders and grantees alike, and providing technical assistance to help their grantees collect needed data. With these dollars in hand, community-based organizations, in turn, must seek to not only improve their data collection capacity, but also actually use the data they collect to improve their everyday practices.

Not surprisingly, the second element needed for this continuous learning process is additional dollars—not only funding to support better data collection as mentioned above, but also for benefits outreach and enrollment efforts in general. Now that Part D and LIS are becoming a "steady-state" part of the Medicare program, LIS outreach and enrollment may be viewed with less urgency as well. With take-up rates for other more long-standing public benefits programs such as the Medicare Savings Programs and Food Stamps at one-third (or less) of the eligible population, this can have devastating consequences for low-income beneficiaries.[11] There needs to be a steady stream of funding to local and state organizations dedicated solely to public benefits outreach and enrollment. While the addition of some funding for a National Center for Senior Benefits Outreach and Enrollment in the 2006 reauthorization of the Older Americans Act[12] was a step in the right direction, more is needed to ensure both access to public benefits for those who need them most and to fuel continued learning in this area to reach even more people in need.

While the initial years of Part D implementation have largely been successful in getting needed prescription drug coverage to millions of people with Medicare, there is still a long road ahead when it comes to LIS outreach and enrollment. The outcomes of efforts like this demonstration and the learnings that it provides can continue to bring us closer to fulfilling the promise of the LIS, the Medicare Savings Programs, and other important benefits, so that people struggling to get by can benefit from the public programs designed to help them.

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[11] Access to Benefits Coalition & National Council on Aging. *The Next Steps: Strategies to Improve the Medicare Part D Low-Income Subsidy. http://www.accesstobenefits.org/library/pdf/TheNextSteps.pdf*. January 2007.

[12] Public Law 109-365, §202 (20) (B)

Epilogue

My Medicare Matters continues its mission to educate and assist those most in need.

My Medicare Community

In March 2007, My Medicare Matters launched a unique online community for professionals and volunteers who help people with Medicare. My Medicare Community offers professionals the chance to learn from each other and from experts in the field, to share promising practices, to try to solve problems together, and to access critical information, training materials, and other educational resources. The content on *www.MyMedicareCommunity.org* is created and organized to focus on issues that are of utmost value to benefits counselors. It responds to the critical need of benefits counselors for a peer-to-peer discussion forum where they can "talk" with one another by posting their ideas, responses and questions about the resources, tools, and topics on the site, no matter where they are located, at any time of day or night. Please visit *www.MyMedicareCommunity.org*

MyMedicareMatters.org and MiMedicareImporta.org

These two Web sites are regularly updated with new information, including information on Medicare preventive services and general information on Medicare Parts A and B. They continue to be the "go-to" sites for simple yet comprehensive and easy-to-understand information on Part D.

My Medicare Matters Navigator

Accessing information over the web is becoming more and more the expected and often times preferred way to learn about Medicare and other healthcare matters. My Medicare Matters wants to help seniors feel comfortable using computers and self-educating themselves on Medicare by learning how to "navigate" the rich resources that are available on the web. Through the Navigator program, senior "Navigators" in senior centers and other sites are being trained to guide consumers through specific, credible Web sites on Medicare and related programs.

Appendix: My Medicare Matters Grantees

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As a companion piece to this report, NCOA has developed an electronic toolkit for community-based organizations who may wish to adopt some of the strategies used by our grantees. The toolkit includes case examples, operational lessons learned, advice, sample materials and tools developed by our grantees, and more. This toolkit is available at: *www.MyMedicareCommunity.org*.


choices
aware
need
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family and friends
care
education
challenges
improvement
helpful
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need
unique
"informed consumers"
counseling
achieve results
corporate
opportunities
new prescription drug coverage
enrollment assistance
personal
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partnership
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education
improvement
valuable
caregivers
challenges
community
need to build
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