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CMCS Informational Bulletin

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SUBJECT: Enrollment and Retention Flexibilities to Better Serve Medicare-Eligible Medicaid Enrollees

Many adults enrolled in Medicaid, including those in the new low-income adult group, will at some point become eligible for Medicare. This Informational Bulletin describes existing flexibilities that can: 1) assist states in meeting their obligations to screen Medicaid enrollees for Medicare Savings Programs and other categories of Medicaid when the enrollees become Medicare-eligible; and 2) improve the stability and continuity of Medicare Savings Program coverage.

Screening for Medicaid and the Medicare Savings Program

When Medicaid enrollees in the new adult low-income group become eligible for Medicare, they lose eligibility for that category of Medicaid. However, before terminating or reducing the scope of Medicaid coverage, the state Medicaid agency is required to assess whether the individuals are eligible for any other category of Medicaid coverage.

Many of these enrollees will continue to qualify for full Medicaid benefits or be eligible for Medicare Savings Programs (MSPs), including the Qualified Medicare Beneficiary (QMB) Program, Specified Low-Income Medicare Beneficiary Program (SLMB), and Qualifying Individual (QI) Program. MSPs cover Medicare beneficiaries' premiums and provide automatic eligibility for the Part D low-income subsidy (LIS). The QMB program also covers beneficiaries' other Medicare cost-sharing obligations. MSPs play a vital role in making Medicare coverage affordable for low-income beneficiaries. Maximizing enrollment in MSPs can also be advantageous to states, as the programs help increase the number of low-income residents who are enrolled in all Parts of Medicare, thus ensuring that Medicare is the primary payer for these individuals.

Aligning Income and Asset Rules

Differences in income and asset rules for different categories of Medicaid eligibility may complicate Medicaid agencies' obligations to screen enrollees properly when the enrollees' Medicaid status changes because they are Medicare-eligible. Most Medicaid enrollees now have their income eligibility determined based on Modified Adjusted Gross Income (MAGI) standards and are not subject to an asset test. When they become Medicare-eligible, however, their

continued eligibility for Medicaid, including for MSPs, may be based on non-MAGI income rules and be subject to an asset limit.

States can simplify their administrative processes by using flexibility under Section 1902(r)(2) of the Social Security Act. For example, states can disregard the income of other individuals, such as spouses, whose income is otherwise countable toward the prospective MSP enrollee. The same provision can also be used to disregard specific amounts of income or categories of assets. In addition, states may use the flexibility authorized under Section 1902(r)(2) to set an overall asset limit at any level above the federal floor, or to disregard all assets. States have the option of using these flexibilities only for MSPs, or they may apply them to other categories of Medicaid as well. Some states have already taken these steps.

Adopting these flexibilities affords multiple advantages to states, including:

- Reducing burden on beneficiaries and the state agency
- Promoting continuity in coverage and care
- Generating administrative savings for states by simplifying verification procedures for income, and eliminating steps needed to verify assets (e.g., Alabama, Mississippi, and New York have reported some administrative savings from eliminating asset tests)

Simplifying MSP Redeterminations

Once beneficiaries are enrolled in MSPs, states can use existing flexibilities to enhance beneficiaries' retention of their MSP eligibility. Federal law requires that Medicaid agencies redetermine MSP enrollees' eligibility once every twelve months; there is no requirement that redetermination be done more frequently. Because enrollees qualifying for Medicaid under Modified Adjusted Gross Income (MAGI)-based eligibility must only be redetermined annually, and because MSP eligible populations typically experience limited fluctuation in income, state Medicaid agencies may find it advantageous to adopt the same redetermination schedule for MSPs to simplify administration.

States also have multiple tools to streamline the redetermination process, thereby avoiding unnecessary coverage lapses and minimizing administrative burdens related to closing and re-opening cases, including the following:

- Use available data sources. Federal regulations (42 CFR §435.916(a)(2) and (b)) require states to use available information whenever possible when conducting redeterminations. MSP participants' circumstances can be particularly amenable to these *ex parte* redeterminations, as these beneficiaries often rely primarily on stable, federal income sources such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), which can be verified by the agency electronically without contacting the beneficiary. If there is no change in circumstances, no action is required of the beneficiary.
- Reduce steps in processes. Eliminating processes such as in-person interviews, signing renewals forms, or filling out new applications, eases burdens on beneficiaries, increasing the likelihood of uninterrupted coverage. Where additional or updated information from the beneficiary is needed, use of prepopulated renewal forms can reduce burden and increase retention rates among eligible beneficiaries. These changes also conserve agency

time and administrative resources while assuring, based on a viable data source, that program integrity is maintained.

- Make redetermination more automatic. Even if the agency cannot verify continued eligibility using the *ex parte* process described above, as long as the agency does not have access to information indicating a beneficiary's circumstances have changed such that she no longer is eligible, it may send a redetermination letter to the enrollee directing her to respond if she has any changes to report; otherwise the individual is automatically renewed.
- Leverage Medicare Advantage Plans as partners. As more beneficiaries have Medicare coverage through Medicare Advantage plans, states may find it worthwhile to share enrollee redetermination dates with Medicare Advantage plans so that plans may assist their members in maintaining MSP eligibility. Such information sharing should be consistent with federal privacy regulations at 42 CFR Part 431, Subpart F, as well as applicable state privacy rules.

As noted, states that have adopted simplified redetermination policies report administrative savings. For example, Louisiana reported annual savings of over one million dollars following the implementation of administrative renewal processes and other streamlined approaches, such as ex parte review and telephone and web-based processes.

Medicare Part A Buy-in Agreement

As with Part B, States may enter into a Medicare Part A buy-in agreement with CMS. Part A buy-in agreements allow low-income individuals to receive premium-free Part A. These agreements target individuals who are otherwise eligible for QMB but who cannot afford Medicare Part A because they have not worked the required number of quarters of Medicare-covered employment to receive premium-free Part A.
To date, 36 States and the District of Columbia have entered into a Part A buy-in agreement. Advantages of this agreement include:

- Allowing the State to enroll Medicare beneficiaries eligible for QMB benefits into Medicare Part A at any time of the year, without late enrollment penalties.
    - In states without a buy-in agreement, these individuals can only enroll in Part A at specific times of year, and states are responsible for paying a late-enrollment penalty.
- Providing financial benefits for states as well beneficiaries because the agreements result in Medicare Part A, rather than Medicaid, becoming the primary payer for inpatient services.
- Creating further opportunities to streamline administration. States may:
    - Automate enrollment of SSI recipients with Medicare Part B into the Part A buy-in on a monthly basis.
    - Exchange data between the State and CMS frequently, e.g. on a daily instead of monthly basis, to reduce delays in the individual receiving benefits.

States without a buy-in agreement with CMS are free to enter into an agreement at any time. State Medicaid agencies can obtain more information about entering into one by emailing statebuy-in@cms.hhs.gov with "Part A Payer Conversation" in the subject line.

Building on Other Recent Improvements to MSP Rules

In recent years, a number of changes to MSP rules have made it easier for eligible beneficiaries to qualify for MSP. States should take the opportunity verify that their policies and materials, including application forms, reflect these updated policies, including:

- Increasing asset levels for QMB, SLMB, and QI programs to that of Part D LIS, and adjusting annually for inflation (see Section 112 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA)).
- Disregarding annual increases in income due to Social Security Cost of Living Adjustments (COLAs) until the annual federal poverty guidelines take effect (see Section 1905(p)(2)(D) of the Social Security Act).
- Eliminating estate recovery for MSP benefits, i.e., premium, deductible, and co-insurance (see Section 115 of MIPPA).

Medicaid enrollees who become eligible for Medicare are often also eligible for continued coverage under different categories of Medicaid, including Medicare Savings Programs. Adopting the flexibilities outlined in this Informational Bulletin can help improve the continuity and stability of coverage for these beneficiaries. A number of these provisions can also enhance administrative efficiencies for states. For additional information about implementing these flexibilities, please contact Gene Coffey at 410-786-2234 or Gene.Coffey@cms.hhs.gov.