CENTER FOR MEDICARE EDUCATION

ISSUE BRIEF
VOL. 5, NO. 3, 2004

www.MedicareEd.org

Medicare Savings Programs: Helping Your Clients Get and Use the Benefits

ABOUT THIS BRIEF

Like those who are eligible for full Medicare and full Medicaid, people eligible for the Medicare Savings Programs are also referred to as dual eligibles or dual enrollees. And like their counterparts, they face special access and eligibility issues. In this second brief in our series on dual enrollees, we discuss issues that your clients may face as they seek to enroll in and use Medicare Savings Programs.

Special thanks to our guest author this month, Patricia Nemore of the Center for Medicare Advocacy, Inc.

Medicare's cost-sharing requirements—monthly premiums, annual deductibles and co-insurance—are significant and can impose barriers to health care for your clients, especially those with low incomes. About 40 percent of people with Medicare, or 16 million people, have incomes below 200 percent of the federal poverty level (FPL) ($18,620 per year in 2004).[1] For these beneficiaries, Medicare Savings Programs (MSPs), first created in 1986 and expanded several times since then, offer relief from some or all of the Medicare cost sharing.

MSP benefits are Medicaid benefits and are administered through state Medicaid programs; to enroll, your clients must complete an application through Medicaid and, in most states, document their eligibility. Despite the possibility of savings of more than $2,000 per year for some MSP enrollees, all of these programs have been significantly under-subscribed throughout their history. Conservative estimates suggest that about 40 percent of people eligible for the two most popular MSPs are not enrolled.[2]

Barriers to enrollment have been identified by numerous reports and studies.[3] These barriers include restrictive asset ceilings used to determine eligibility; lack of effective outreach to program beneficiaries; and lack of knowledge of the programs on the part of those who might help people enroll (such as welfare workers, Social Security Administration employees and employees of community-based organizations). In addition, cumbersome and obstacle-laden enrollment processes that require long waits in welfare offices, face-to-face interviews, and extensive documentation of income and assets; difficulties with language and transportation; and Medicaid-required estate recovery in some states contribute to low enrollments. However, some states have reduced these barriers in recent years in order to improve access to the benefits.

Benefits for people with low incomes under the new Medicare-endorsed prescription drug discount cards and the Medicare Part D benefit that starts in 2006 have eligibility rules similar to those for MSPs. Possibilities for overlapping enrollment between the two programs exist; moreover, understanding issues that have arisen for MSP-eligible individuals may promote smoother enrollment for the low-income drug benefit.

In this brief, we discuss issues that your clients may face as they seek to enroll in and use MSPs. Like those who are eligible for full Medicare and full Medicaid, MSP-eligible individuals are also referred to as dual eligibles or dual enrollees. About one million of the more than 7 million dual enrollees are eligible only for one of the MSPs. It is the access issues of those one million people that are the primary focus of this brief.

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A project of the American Association of Homes and Services for the Aging with funding from the Robert Wood Johnson Foundation.

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What are the Medicare Savings Programs?

Medicare Savings Programs create special categories of Medicaid eligibility. The state must provide the limited benefits of each category, but it is not obligated to provide additional Medicaid benefits (unless your client is also eligible under a separate category). Currently, four MSP categories exist: Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, Qualified Individual and Qualified Disabled and Working Individual. Each category has slightly different eligibility rules.

QUALIFIED MEDICARE BENEFICIARY

Eligibility. A Qualified Medicare Beneficiary (QMB) must have Medicare Part A (whether premium-free or through enrollment and payment of a monthly premium), countable income not more than 100 percent of the FPL ($796/month in 2004)[4], and countable assets of not more than $4,000 ($6,000 for a couple).

Benefit. QMBs pay no Part B (or Part A, if applicable) premium, no annual deductible and no cost sharing. Medicaid pays the premium and to varying degrees, as discussed below, the other cost sharing. QMBs' relief from cost sharing covers all Medicare benefits, regardless of whether those benefits are also offered under the state's Medicaid program. Benefits are available in the first month after eligibility is determined. The benefits are an entitlement, which means that each person who applies for QMB and is found eligible receives the benefit.

Relationship to full Medicaid. QMBs may also be entitled to full Medicaid benefits if they qualify under another Medicaid eligibility group. In states without medically needy programs for non-institutionalized individuals, nearly all non-institutionalized dually enrolled Medicaid beneficiaries should also qualify for QMB benefits.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARY

Eligibility. Like a QMB, a Specified Low-Income Medicare Beneficiary (SLMB) must also have Medicare Part A, countable income between 100 percent and 120 percent of the FPL ($951/month in 2004) and countable assets of not more than $4,000 ($6,000 for a couple).

Benefit. The benefit consists of coverage of the Medicare Part B premium ($66.60/month in 2004). Unlike a QMB, an SLMB may receive benefits for three months prior to application, if he or she was eligible during those months. SLMB benefits, like those of QMB, are an entitlement.

Relationship to full Medicaid. Like a QMB, an SLMB may also receive full Medicaid benefits.

QUALIFIED INDIVIDUAL

Eligibility. Like QMBs and SLMBs, a Qualified Individual (QI) must have Medicare Part A, an income between 120 and 135 percent of the FPL ($1,068/month in 2004) and countable assets of $4,000 or less ($6,000 or less for a couple).

Benefit. As with an SLMB, the benefit is payment of the Medicare Part B premium, and benefits may be awarded up to three months retroactively. The QI benefit, however, is *not* an entitlement. Rather, it comes from a block grant to states; if your client is found to be eligible after the state's money has run out, he or she cannot get benefits. The QI program is scheduled to expire on September 30, 2004.

Relationship to full Medicaid. Unlike a QMB or SLMB, a QI may *not* receive full Medicaid benefits.

QUALIFIED DISABLED AND WORKING INDIVIDUAL

Eligibility. A Qualified Disabled and Working Individual (QDWI) is someone who is disabled and working in a work incentive program and who is no longer entitled to received premium-free Medicare Part A. His or her countable income must not be more than 200 percent of the FPL ($1,572/month in 2004), and countable assets cannot be more than $4,000 ($6,000 for a couple).

Benefit. The benefit consists of payment of the Part A premium ($343/month in 2004) and, like SLMB and QI, is available for up to three months prior to application. QDWI benefits are an entitlement.

Relationship to full Medicaid. Like a QI, a QDWI cannot otherwise be eligible for Medicaid.

Issues and Challenges Facing All MSP-Eligible Persons

OUTREACH: USE OF FEDERAL DATA TO IMPROVE ENROLLMENT

Lack of knowledge of MSPs by their intended users has plagued these programs since their inception. To correct that problem, Congress, in 1994, directed the Secretary of Health and Human Services to collect and send to the states information from new Medicare beneficiaries that would indicate their eligibility for cost sharing assistance.[5] Although the Secretary does not collect such information from beneficiaries, he does provide to states, on request, lists of newly enrolled Medicare beneficiaries whose Social Security incomes are less than 100 percent of the FPL. These data, called leads data, can be used for direct mailings to potential beneficiaries, for cross-checking against existing Medicaid rolls to directly enroll individuals in the QMB program, and for other targeted outreach and enrollment activities. At this time, 23 states request and receive the data from the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees Medicare and Medicaid.[6] If your state does not receive such data, you might work with your State Health Insurance Assistance Program (SHIP) to persuade the state to get the data and use them to inform beneficiaries about the MSPs. If your state does receive the data, you can find out how it uses them and how you could participate in implementing a targeted outreach strategy.

ESTATE RECOVERY

Another reason often cited for lack of participation in MSPs is the possibility that beneficiaries will be subject to recovery of the benefits from their estates after they die. You can help your clients by knowing your state's policy with respect to estate recovery and helping them understand exactly what their liability might be, and by joining with others to encourage your state to limit its estate recovery to the minimum required by federal law.

Federal law requires states to recover Medicaid benefits paid for long-term care services under certain limited circumstances.[7] States are authorized, but not required, to recover other Medicaid benefits paid to persons age 55 and older. CMS has directed states that they must recover MSP benefits to the extent they relate to long-term care services, although arguably the law does not require such recovery.[8] However, nothing in law or CMS guidance requires states to recover MSP benefits from people not using Medicaid long-term care services. Sometimes Medicaid applications inform people of estate recovery without distinguishing which benefits are included, and other times people hear rumors that they will lose their home if they take Medicaid benefits. Solid information about your state's recovery policies can help calm your clients' fears and let them enroll in the programs.

INDEXING OF BENEFIT ELIGIBILITY

Occasionally you may find that a client has been terminated from MSP benefits due to excess income at the beginning of a new year. At least for those clients whose income is from Social Security benefits, this should not happen, and it can be corrected. The problem of excess income arises from the use of two different indexing effective dates. Social Security cost of living adjusters (COLAs) are effective January 1, but the income poverty guidelines that index MSP benefit levels are not published until February or March and are effective the month following publication. MSP law acknowledges this glitch and requires that COLAs be disregarded until the second month after the new FPLs are published.

Issues and Challenges Facing Qualified Medicare Beneficiaries

PART A ENROLLMENT

To be eligible for QMB benefits, your client must be entitled to or enrolled in Part A Medicare. Most Medicare beneficiaries are entitled to Part A (premium-free) because of their records in Social Security-covered work. People 65 and older without premium-free Part A can purchase it for $343/month (in 2004).[9] This amount, however, can be exorbitant for someone who is QMB-eligible; it is nearly 45 percent of monthly income. So your QMB-eligible client needs the state-paid Part A premium that is part of the QMB benefit in order to qualify for the benefit.

This conundrum is addressed in two ways. The most beneficiary-friendly way is for the state to have a Part

A buy-in agreement with the federal government that allows the state to enroll someone in Part A at any time of the year and make that person eligible for QMB benefits. An added advantage of a Part A buy-in agreement, for the state, is that the state is excused from paying any late enrollment fee that might be assessed if your client did not enroll in Part A when he or she was first eligible to do so. Although 34 states have Part A agreements,[10] not all those states automatically enroll potential QMBs who are lacking Part A into the program. Some of those states, as well as states without Part A buy-in agreements, require conditional enrollment in Part A.

Conditional enrollment is a complex and cumbersome process whereby someone enrolls in Part A on the condition that he or she is eligible for QMB. If your state uses it, you might want to look for ways to encourage your state to abandon it and, if necessary, enter into a Part A buy-in agreement with CMS. In the meantime, you can help your clients by explaining the process to them and following up with them. First, you should call the local Social Security Administration (SSA) office and your state Medicaid agency to be sure they know about and honor conditional enrollment. If they do, send your clients to the SSA office and have them ask to enroll in Part A Medicare conditioned upon their state paying the premium under the QMB. They should write this down on their application, get a copy of the application and bring it to the state agency where they apply for MSP benefits. If you live in a state without a Part A buy-in agreement, they will only be able to do this during the initial Medicare enrollment period or during an annual general enrollment from January through March. If they enroll during general enrollment, their Part A will be effective July 1 of that year.

Even if your clients have full Medicaid benefits, there may be advantages to enrolling them in Part A if they do not have it. (Not all states automatically enroll their QMB-eligible full Medicaid beneficiaries into QMB.) Advantages of Part A include additional hospital and skilled nursing facility coverage, the possibility of better rehabilitation/therapy coverage and reduced liability for Medicaid estate recovery.

ACCESS TO PROVIDERS

Your clients whose only Medicaid benefit is the QMB benefit—relief from all Medicare cost sharing—may find that their usual providers are reluctant to accept the QMB benefit, especially if those providers do not usually serve Medicaid beneficiaries. Two circumstances may explain this reluctance.

Administrative requirements for Medicaid providers. Medicaid requires that all providers who seek reimbursement from the program must be Medicaid providers, a status that requires executing a provider agreement with the state. State processes vary, but the provider's perception or the reality may be that the process is cumbersome. In fact, federal law states that a provider agreement necessary for participation to serve a QMB "may be executed through the submission of a claim to the Medicaid agency requesting Medicaid payment for Medicare deductibles and co-insurance for QMBs."[11] It is possible that not all states follow this procedure of limited provider agreements, or that providers serving QMBs are not aware that they can receive payment merely by submitting a claim. You can help your clients by explaining this to providers and, if necessary, to your state.

Payment of less than full Medicare cost sharing. At least 35 states reimburse some or all providers serving QMBs at rates less than the full Medicare cost-sharing amount. They are able to do this because of a provision included in the Balanced Budget Act of 1997 (BBA) that authorized states to pay at the Medicaid rate, even if that rate was lower than the Medicare-approved amount. Under this BBA provision, if the Medicare-approved amount for a physician's visit is $100 (so that the beneficiary's responsibility, if she were not a QMB, would be $20) and the state's Medicaid payment for the same service is $70, the state need pay nothing. This is because Medicare has already paid $80, which is more than the state's whole payment under Medicaid. If the state Medicaid payment for the service is $90, the state would have to pay at least $10, the difference between Medicare's payment of $80 and its own allowable amount of $90. Prior to the BBA, 31 states paid full Medicare cost sharing. (Arguably, the other 20 jurisdictions were in violation of the law, although CMS has always taken the position that states could pay at the lower Medicaid rate, if they chose to do so.[12])

Although a congressionally mandated study released in May 2003 reported that the lower rates that states are paying affect access to services for QMBs, the study did not examine whether less access to services resulted in bad health outcomes, nor did it recom-

mend any legislative changes to alter the payment situation.[13]

Included in the BBA, in an effort to mitigate the effects of the payment reduction on QMBs, was a provision that prohibits providers from billing QMBs any amounts above what is paid by Medicare and, if any, by Medicaid. However, CMS permits providers to circumvent this provision by declaring that they will not serve QMBs as QMBs. If they inform their patients that they are not accepting their QMB status, providers are free to bill QMBs for Medicare cost sharing, and if they are not Medicare participating providers and thus required to accept assignment, they can bill above the Medicare-approved charges.[14] You can help your clients by advising them to show their QMB card to the providers; if providers do not state that they will not serve them, they cannot bill them for anything except a co-payment that might be required by the *state*, not by Medicare.

CO-PAYMENTS TO MEDICARE+CHOICE (NOW MEDICARE ADVANTAGE) PLANS

Although not many dual eligibles, including QMBs, are enrolled in Medicare HMOs and other Medicare+Choice (M+C) plans, you may, nonetheless, have clients who are QMBs and receive their Medicare services through an M+C plan. These clients are entitled to have Medicaid pay their M+C co-payments (although the state is not required to pay any additional premium the M+C plan might charge).[15] However, because there is not automatic "cross-over" billing from Medicare to Medicaid as there is in the fee-for-service program, there may not be a system in your state for providers to bill Medicaid for the co-payments. You can help your clients by informing M+C providers serving them that they are not permitted to bill them the co-pays, and by finding out your state's procedure, if any, for M+C providers to be reimbursed for co-pays.

In Conclusion

Issues affecting dual enrollees in general and MSP beneficiaries in particular are receiving more attention since passage of the Medicare Modernization and Prescription Drug Act of 2003. That law includes low-income Medicare benefits with eligibility rules similar, though not identical, to those of the MSPs. Although these new rules may well add to, rather than reduce, confusion in administration of benefits for low-income Medicare beneficiaries, there is at least more attention being paid to dual eligibles at the federal level. CMS recently inaugurated an e-mail address for correspondence concerning dual eligibles: dualeligibles@cms.hhs.gov. If you are unable to resolve issues for your MSP clients at the state level, you may want to correspond with CMS.

Deeper understanding of the issues facing MSPs will help you to assist your low-income clients to get the benefits to which they are entitled under those programs and to qualify for Medicare's low-income prescription drug benefits.

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[1] Kaiser Family Foundation, *Fact Sheet - Medicare-Medicare at a Glance*, Washington, March 2004, Kaiser Commission on Medicaid and the Uninsured, *Key Facts: Dual Enrollees: Medicaid's role for Low-Income Medicare Beneficiaries*, Washington, February 2003.

[2] Rupp, K. , and Sears, J. *Eligibility for the Medicare Buy-in Programs, Based on a Survey of Income and Program Participation Simulation*. Baltimore, Social Security Bulletin. 2000.

[3] Glaun, K. *Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs Case Study Findings*, The Kaiser Commission for Medicaid and the Uninsured, 2003; Nemore, P. *Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries: A 1999 Update*, The Henry J. Kaiser Family Foundation, 1999; General Accounting Office, *Low Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment*, GAO-HEHS-99-61, 1999; and AARP Policy, *Bridging the Gaps Between Medicare and Medicaid: The Case of QMBs and SLMBs*, 1999.

[4] Certain income and assets are *not* included – or counted – when determining eligibility. For example, the first $20 of any income is excluded. Some excluded assets are a house, a car, household possessions, some burial funds and a small amount of life insurance.

[5] Pub. L. 103-432, Title 1, Sec. 154. The law explicitly directs that information be collected with respect to QMBs; arguably its potential reach is, all MSP beneficiaries.

[6] The states are Alabama, Arkansas, California, Connecticut, District of Columbia, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Louisiana, Maryland, Minnesota, Mississippi, Missouri, New Mexico, North Carolina, Ohio, Pennsylvania, South Dakota, Utah, Virginia and Wyoming. Information provided in e-mail from Robert Nakielny, CMS, to Patricia Nemore, Center for Medicare Advocacy, Inc., March 3, 2004.

[7] 42 U.S.C. § 1396p(b).

[8] The Centers for Medicare and Medicaid Services. State Medicaid Manual, Sec. 3810. http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp

[9] The amount of the premium is less if the individual has 30-39 quarters of Social Security coverage.

[10] States that do *not* have Part A buy-in agreements are: Alabama, Arizona, California, Colorado, Illinois, Kansas, Kentucky, Louisiana, Missouri, New Jersey, New Mexico, New York, Oregon, South Carolina, Utah and Virginia. Effective July 1, 2004, New York will have a Part A buy-in.

[11] The Centers for Medicare & Medicaid Services. State Medicaid Manual, Sec. 3490.14B., http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp.

[12] Department of Health and Human Services, Health Care Financing Administration, Transmittal No. 31, State Medicaid Manual, Part 3 - Eligibility. December 1988.

[13] Tommy G. Thompson, Secretary of Health and Human Services, *Report to Congress State Payment Limitations for Medicare Cost Sharing* transmitted to the Honorable J. Dennis Hastert, Speaker of the House of Representatives, May 20, 2003.

[14] The Centers for Medicare & Medicaid Services. State Medicaid Manual, Sec. 3490.14 B, http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp.

[15] The Centers for Medicare & Medicaid Services. State Medicaid Manual, Sec. 3490.12, http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp.

About the Author

Patricia Nemore, an attorney with the Center for Medicare Advocacy, Inc., has been an advocate for older people and people with disabilities seeking health care for more than 20 years. Her practice has focused on Medicare, Medicaid and long-term care, with special emphasis on issues of importance to those dually eligible for Medicare and Medicaid. She has engaged in individual advocacy, class action litigation, and legislative and administrative advocacy at the national level. She graduated from the Columbus School of Law of the Catholic University of America.

The Center for Medicare Advocacy, Inc., founded in 1986, is a national, non-partisan education and advocacy organization that identifies and promotes policy and advocacy solutions to ensure that elders and people with disabilities have access to Medicare and quality health care. The organization provides training regarding Medicare and health-care rights throughout the country and serves as legal counsel in litigation of importance to Medicare beneficiaries nationwide. The organization's national office is in Connecticut, with offices throughout the country, including in Washington, D.C. For more information about the Center for Medicare Advocacy, Inc., visit www.medicareadvocacy.org.

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