Building a Stronger Foundation for Medicare-Medicaid Integration: Opportunities in Modifying State Administrative Processes

IN BRIEF

Many states are interested in providing a more integrated and coordinated system of care for individuals who are dually eligible for Medicare and Medicaid. This brief describes several administrative changes that state Medicaid programs can make to: (1) support integration efforts; (2) improve beneficiaries' experience of care; (3) decrease beneficiary out-of-pocket costs; and (4) reduce provider burden. Taking the steps described in this brief may help states build stronger, more effective integrated care programs and better position them to implement larger-scale integration efforts for their dually eligible populations.

Many states are interested in providing a more integrated and coordinated system of care for individuals who are dually eligible for Medicare and Medicaid. While some states have made considerable strides in the development of integrated care programs, others are in a more exploratory phase. Regardless of the integration approach a state is considering or where it is in the process of implementation, there are a number of administrative changes that a state can make to build a stronger foundation for integrated care.

The administrative changes described in this brief support state integration efforts while potentially improving beneficiaries' experience of care, decreasing beneficiary out-of-pocket costs, and reducing provider burden. For each approach, this brief explains: (1) the opportunity; (2) how it supports integration; and (3) and the potential costs and administrative requirements of implementation. Making these suggested changes may help states build stronger, more effective integrated care programs and better position them to implement larger-scale integration efforts for dually eligible populations.

Administrative Initiatives to Improve Integration

1. Offer DME Authorization Prior to Medicare Denial

Medicaid and Medicare coverage for durable medical equipment (DME) differs in sometimes complex ways, making it difficult for some dually eligible beneficiaries to access these services. Determining whether a specific DME item is covered by Medicare or Medicaid makes obtaining authorization particularly challenging. Currently, most states require DME suppliers to submit claims to Medicare first, and adjudicate Medicaid coverage only after Medicare issues a final payment denial. However, since Medicare does not authorize final payment until after a DME product has been delivered, both suppliers and beneficiaries may face uncertainty about who will pay and/or whether an item will be covered when Medicare and Medicaid coverage overlaps.[1] DME providers may be reluctant to provide services without

prior assurance that they will ultimately receive payment. As a result, dually eligible beneficiaries may experience delays in acquiring medically necessary DME items, especially those items that are most costly.

In January 2017, CMS issued an informational bulletin that offered examples of strategies states might pursue to help beneficiaries have more timely access to DME, prosthetics, orthotics and supplies (DMEPOS).[2] In the bulletin, CMS encouraged states to offer suppliers a way to request Medicaid prior authorization of more costly DMEPOS for dually eligible beneficiaries.

Description of the opportunity: To improve beneficiary experience and reduce administrative burden related to DME, states can offer preliminary or provisional Medicaid authorization for DME prior to Medicare denial and/or provide other resources to assure DME providers of Medicaid coverage for certain items that are likely to be denied Medicare coverage. Examples of states that have implemented such policies include:

- **Connecticut:** In 2009, the state implemented a statute that allows its Medicaid administrative services organization (ASO) to prior-authorize coverage of a DME item before it receives a formal denial from Medicare. The ASO cannot pay for an item or service until Medicare makes a formal denial, but this relatively simple process gives providers assurance that they will be reimbursed once the product has been delivered.
- **Illinois:** The state has taken steps to help dually eligible beneficiaries acquire DME. Illinois maintains an online table that specifies the DME items/services for which providers can bill Medicaid directly, because Medicare generally does not cover them under Part B.[3] The Illinois DME fee schedule includes other key information, such as the maximum quantity of certain DME items/supplies that may be billed to the state's Medicaid program. In addition, providers in Illinois have access to an electronic eligibility verification system called MEDI, which displays several elements of a beneficiary's eligibility, including whether a beneficiary is enrolled in Medicare or eligible for Medicare cost-sharing via the Qualified Medicare Beneficiary (QMB) program, as well as whether a dually eligible beneficiary is enrolled in a Medicare-Medicaid Plan (MMP) through the Financial Alignment Initiative demonstration in the state. Providers can use MEDI to determine whether a beneficiary is dually eligible for Medicare and Medicaid and when to submit claims to an MMP instead of fee-for-service Medicare and Medicaid.
- **California:** Similar to Illinois, the California Department of Health Care Services (DHCS), Medi-Cal's parent agency, maintains an online list of Healthcare Common Procedure Coding System (HCPCS) codes for DME items or services that providers can bill directly to the state's fiscal intermediary as "straight Medi-Cal claims." Providers are not required to submit claims to Medicare first for DME items or services that appear on the list of those that Medicare does not cover, but that Medicaid may.[4] Because the document is publicly available, providers can assess in advance which program ultimately will or will not cover the item. In addition, the document includes specific guidance on when a provider should bill Medi-Cal directly.

How this opportunity supports integrated care: As noted above, differences in Medicare and Medicaid coverage of DME can be difficult for beneficiaries and providers to navigate. Providers may be reluctant to supply medically necessary DME items to dually eligible beneficiaries because of uncertainty about who will pay for them and when. The processes described above reduce access problems by clarifying which payer should be billed in which circumstances, and offering providers reasonable assurance that Medicaid will cover items that Medicare may not.

Implications for cost and administrative burden: By offering DME authorization prior to Medicare denial, states may help to alleviate provider burden and potentially reduce Medicaid program costs that occur when dually eligible beneficiaries' health or functional status declines after they cannot access needed DME.

2. Submit MMA files to CMS More Frequently

Since 2006, states have submitted "MMA" files[5] to CMS to identify all full and partial dually eligible beneficiaries. States must submit the MMA file at least monthly to CMS, but can do so as often as daily.

Description of the opportunity: State Medicaid agencies can submit MMA data files more frequently. State Medicaid leaders may not be aware of the MMA file's existence or the reason the state decided to submit only monthly when the data exchange process was built a decade ago.

How this opportunity supports integrated care: More frequent file submissions promotes faster access to Medicare subsidies and billing protections. Specific benefits include:

Increased State Efficiencies

- **Faster transition to Medicare drug coverage.** The sooner a beneficiary transitioning from Medicaid drug coverage to Medicare Part D drug coverage gets auto-enrolled into a Medicare drug plan, the fewer the claims paid erroneously by the state and the less money the state has to recoup from pharmacists (who then have the burden of reaching out to reconcile with the new Part D plan).
- **Faster turnaround to Medicare as primary for other services.** More frequent file submission increases the speed of identifying new Medicare Part A/B enrollment, so states can more quickly implement edits to ensure that Medicaid does not cover those Medicare services. This also has the benefit of reducing oversight risks related to audits on third party liability.
- **Streamlined error identification/resolution.** When data errors (e.g., transposed numbers) exist within MMA files, some back-and-forth may be needed to correct the error. These issues have a better chance of getting fixed before the start of the next month if files are transferred more frequently.
- **Support for enrollment in integrated care.** Particularly for new dually eligible beneficiaries, more frequent data exchange helps states get people enrolled in integrated products earlier (e.g., Dual Eligible Special Needs Plans, Medicare-Medicaid Plans).

Improved Beneficiary Access to Care

- **Faster access to Medicare subsidies.** Dual status on the MMA file prompts CMS to deem individuals eligible for the Medicare Part D low income subsidy (LIS) as well as make changes to that status (e.g., prompted by a move to a nursing facility or use of home- and community-based services) and auto-enroll them into Medicare drug plans back to the start of dually eligible status.
- **More efficient communication.** More frequent file submission allows for more efficient communication to Qualified Medicare Beneficiaries (QMBs) regarding zero liability for Medicare Part A/B cost sharing, and protections from providers billing them for it. A lag in data exchange could cause confusion for these beneficiaries, as they may receive Medicare Summary Notices in the interim showing liability for cost-sharing.

Reduced Provider Burden

- **Support compliance.** Medicare provider and health plan compliance with restrictions on billing QMBs for cost-sharing for services covered by Medicare Part A and B can also be supported by frequent file submission. CMS notifies FFS providers of QMB status via its eligibility query (HETS) and claims processing (provider remittance advice) systems, based on data submitted on the MMA file. Lags in data can cause confusion for providers and beneficiaries, and possibly increase administratively burdensome inquiries to the state. For example, delays in data can cause access problems for those new to QMB.
- **Alleviate the burden on pharmacists.** The sooner a beneficiary transitioning from Medicaid drug coverage to Medicare Part D drug coverage gets enrolled into a Medicare drug plan, the fewer claims paid erroneously by the state and the fewer the state will have to recoup from pharmacists (who then have the burden of reaching out to reconcile with the new Part D plan).
- **Implications for cost and administrative burden.** Currently, thirteen states (AR, DE, GA, IA, MA, MO, MS, NE, NJ, NV, OH, OR, and, RI) submit MMA files to CMS on a daily basis. Twelve states (AK, AL, AZ, CA, CO, ID, ME, NM, PA, VT, WI and WY) submit on a monthly basis. The remaining 26 states submit their MMA files more frequently than monthly, but less than daily (e.g., weekly, bi-weekly, etc.). States will need to determine if administrative and data systems will support more frequent submission of the MMA data files. If changes are needed to support more frequent submission, states will have to determine what those costs are and if they are outweighed by the benefits outlined above.

3. Execute a Part A Buy-in Agreement with CMS

Most Americans age 65 and older receive premium-free Medicare Part A, which covers hospital, skilled nursing facility and other institutional costs, because they paid into the Medicare trust fund through their or their spouse's employment. However, some low-income individuals may be ineligible for this benefit, including those who have not worked a required number of quarters to receive premium-free Part A. These individuals must pay a premium to enroll in Part A. In 2018, Medicare Part A premium costs range from $232 to $422 per month,[6] a significant financial burden for low-income individuals, potentially leading them to decline Part A enrollment. Fortunately, states are required to pay the Part A premium (up to $422 in 2018) in addition to Part B premiums and Part A and B Medicare cost-sharing for individuals who are eligible as Qualified Medicare Beneficiaries (QMBs).

Description of the opportunity: All states must pay for Medicare Part A premiums for individuals who are eligible as Qualified Medicare Beneficiaries (QMBs) To facilitate the payment of Part A premiums for QMBs, states may enter into a Medicare Part A Buy-in Agreement with CMS.

Thirty-six states and the District of Columbia have entered into a Part A buy-in agreement.[7] The 14 states without a Part A buy-in agreement use the group payer arrangement to pay Part A premiums but are free to enter into Part A Buy-in agreement at any time.[8]

How this opportunity supports integrated care: State agreements for Part A buy-in provide several advantages for states that can also positively impact beneficiaries. For example, these agreements may help states to:

- Enroll Medicare beneficiaries eligible for QMB benefits into Medicare Part A at any time of the year (outside of designated Medicare enrollment periods) without late enrollment penalties that beneficiaries may otherwise be charged.
- Support Medicare-Medicaid integration activities by facilitating the ability of states to enroll low-income individuals into Part A who are unable to afford it on their own and require QMB status to enroll. Medicare Advantage plans, including D-SNPs, require Medicare Part A and B enrollment. This is particularly important for states seeking to promote aligned enrollment of dually eligible beneficiaries into D-SNPs and Medicaid managed care plans.
- Reduce Medicaid costs by ensuring that dually eligible individuals have Medicare Part A coverage, states can reduce their Medicaid costs because Medicare will pay for hospital or other institutional services for which beneficiaries are eligible.
- Reduce burden on state eligibility staff and beneficiaries by simplifying the application process. Having a Part A buy-in agreement eliminates the need for QMBs to complete a multi-step application process that is time consuming and administratively complex if the person already is enrolled in Part B.[9] In states without a Part A Buy-In Agreement, individuals must use the conditional enrollment process, which involves application and eligibility determinations by both the Social Security Administration and Medicaid.[10]
- Streamline processes and reduce administrative burden by automating enrollment of SSI recipients with Medicare Part B into the Part A buy-in on a monthly basis.[11]

Implications for cost and administrative burden: Enrolling more persons in Medicare Part A helps to maximize federal funding for this population by ensuring that Medicare is the primary payer for their care. States receive federal financial participation (i.e., federal medical assistance percentage (FMAP)) to assist in paying Part A premiums and cost-sharing for QMBs.[12]

Entering a Buy-in Agreement helps to reduce administrative costs and burdens. All states must pay for Part A premiums for the QMB eligibility category, and a Part A buy-in agreement streamlines and eases the processes for a state to do so. States incur minimal administrative costs when executing a Part A Buy-in agreement with CMS.

4. Exchange Medicare Buy-in Files with CMS More Frequently

State Medicaid agencies and CMS also regularly exchange Medicare Buy-in data to identify Medicare enrollment for certain Medicaid recipients and the state's liability for their Medicare Parts A and/or B premiums.

To pay, terminate, or modify premium payments for an individual, a state must submit a beneficiary transaction record to CMS on a "buy-in" file. CMS responds to each state buy-in file record by sending a file that identifies whether CMS accepted, rejected, or changed it and contains a billing record to indicate the state's premium liability. CMS also regularly sends Medicaid agencies new buy-in updates that it initiates or receives from the Social Security Administration. States must submit buy-in data to CMS on at least a

monthly basis, but have the option to exchange data with CMS daily or weekly. Similarly, states can receive the CMS buy-in response file on a daily or monthly basis.

Description of the opportunity: By choosing to submit and receive buy-in files daily, states can promote more timely access to coverage and lessen burden for themselves and beneficiaries. As of July 2018, 31 states submit buy-in data to CMS daily; 29 states receive buy-in response files from CMS daily.

How this opportunity supports integrated care: Access to Part A/B services, including primary and specialty physicians, screening and diagnostic tests, and medical supplies and equipment, is a crucial component to providing integrated care. The preventive care and services provided by Part B can help beneficiaries to maintain their health, avoid hospitalizations, and defer the need for long-term services and supports. Specific benefits of daily data exchange include:

- **Quicker beneficiary access to Medicare Parts A/B services.** Less frequent exchange prevents states from quickly activating buy-in coverage and can result in significant delays in Medicare enrollment. Buy-in transaction errors can require repeated actions to rectify and reprocess. As a result, in states with a monthly buy-in exchange, errors can take multiple months to remedy. States with a daily exchange can detect and correct errors more quickly, limiting the impact of errors and allowing for more immediate Medicare enrollment.
- **Ability to enroll in Medicare Advantage.** Individuals need to be enrolled in both Medicare Part A and Part B to be eligible for enrollment in a Medicare Advantage program, including Dual Eligible Special Needs Plans (D-SNPs), which offer a model of care specifically designed for dually eligible individuals. Enrollment in a D-SNP may also facilitate the beneficiary's enrollment in a program that integrates and coordinates both Medicare and Medicaid services.
- **Avoiding burdensome out-of-pocket costs.** Most Medicare beneficiaries pay premiums through deductions from their Social Security checks. As described above, daily data exchange means that premium deductions will can stop more quickly.

Implications for cost and administrative burden: Moving to daily data exchange with CMS can enable a faster shift to Medicare as primary payer, helping to offset expenditures by Medicaid. Further, daily buy-in exchange can reduce states costs by allowing states to more quickly terminate buy-in coverage and lower the risk of paying Part A or B premiums for persons who no longer qualify.

Although states may need to make additional investments in data systems and validation processes, states can achieve administrative savings overall with more frequent data exchange. In a monthly exchange, the added lag in updating data and correcting transaction errors increases the degree to which payments for premiums or services must subsequently be recouped and redistributed, an administratively burdensome process involving debits and payments between the beneficiary, states, CMS and SSA. Daily buy-in exchange helps to minimize mis-payments and the administrative costs associated with recoupment and redistribution processes. Additionally, spreading the receipt of data files across the month may help states even out their staffing needs. (Note that CMS will send a monthly report as well, so a state could still wait to view the data on a monthly basis if that would better for staffing in a particular month.)

5. Disregard Certain Assets for MSPs to Align with LIS Process

States can reduce administrative burden by aligning their Medicare Savings Program (MSP) asset disregard policies with those of Medicare's Low Income Subsidy (LIS) program. Depending on a dually eligible beneficiary's income and assets, a state's MSP pays for Medicare Part A and B premiums, and in some cases, cost sharing.[13,14] Medicare's LIS program helps beneficiaries with low income and assets pay for Part D prescription drugs. While LIS eligibility rules are determined at the federal level, states have flexibility in how they calculate income and assets set out in federal MSP eligibility rules. All states use monthly income limits to determine MSP eligibility, and most use asset limits as well. State MSPs, however, must set their asset limits to an amount at least as high as federal LIS asset limits pursuant to the Medicare Improvements for Patients and Providers Act (MIPPA).[15] States have the option to disregard certain income or assets, resulting in higher income and asset limits than federal LIS limits in order to cover more beneficiaries. In 2018, four states used effectively higher income limits for their MSP programs than the federal LIS minimum limit,[16] and 11 states used higher asset limits (with nine states having no asset limit for MSP).[17]

Description of the opportunity: States can streamline beneficiary access to benefits and promote integrated care by aligning MSP asset disregard policies with those of LIS. Identifying which types of assets, such as household goods and bank accounts, are counted towards LIS and MSP asset limits is a critical component of eligibility determinations. For example, a state may count savings accounts, but disregard life insurance policies. In all states, the following assets are never counted in MSP determinations: an individual's primary house; car; household goods and wedding/engagement rings; burial spaces; burial funds up to $1,500; and life insurance with a cash value of up to $1,500. ***Exhibit 1*** shows how assets are considered for the federal LIS asset test.

Exhibit 1. Assets Considered in the LIS Eligibility Process

Counted	Not Counted
▪ Liquid resources including cash and other assets that can be converted to cash within 20 work days[a] ▪ Equity value of non-home real property ▪ Particular trusts[b] ▪ The first-time homebuyer's and deemed first-time homebuyer's tax credits	▪ Home that serves as the individual's principal place of residence ▪ All vehicles, including autos, trucks, motorcycles, boats, snowmobiles, etc. ▪ Household goods and personal effects ▪ Irrevocable burial trusts and contracts ▪ Transfers of resources ▪ Particular trusts ▪ Cash surrender value of life insurance policies[c]

See HI 03030.001 of the Social Security Program Operations Manual System for more details on assets under LIS, available at: https://secure.ssa.gov/poms.nsf/lnx/0603030001

[a] Examples of liquid resources in LIS eligibility determinations include stocks, bonds, annuities, bank accounts, mutual funds, mortgages, retirement accounts, and promissory notes.

[b] A trust may or may not be an asset for LIS, depending on SSI rules. See the Social Security Program Operations Manual System for more information on trust details.

[c] MIPPA specifies that the cash surrender value of a life insurance policy does not count as an asset for LIS for applications filed on or after January 1, 2010, and for initial determinations that do not become effective before January 1, 2010.

States can refer to the Social Security Program Operations Manual System in order to align their MSP asset disregards with LIS asset rules. For example, states such as Colorado and New Jersey[18] disregard the value

of one vehicle from asset determinations, but the LIS process disregards the value of all vehicles. In addition, some states such as Georgia count the cash value of life insurance policies above $1,500, but the LIS process completely disregards the cash value of life insurance.[19]

When asset disregard policies are aligned, states can take advantage of LIS and MSP data sharing opportunities to reduce administrative burden.[20] MIPPA requires the Social Security Administration to send data to states when an individual applies for LIS. Although states are allowed to require additional verification information from applicants, state acceptance of LIS eligibility data without re-verification reduces administrative burden on the state, as well as application burden on the beneficiary.

How this opportunity supports integrated care: When a state disregards certain income or assets, with the result being that it has higher income and asset limits than federal LIS limits, it increases the likelihood that beneficiaries obtain access to MSP to pay for Medicare A/B premiums, thus qualifying for integrated care.

Implications for cost and administrative burden: By aligning MSP asset rules with those used in the LIS process and using LIS eligibility data, states can significantly reduce administrative burden associated with their MSP eligibility processes.

6. Allow Crossover-only Enrollment in Medicaid for Providers

For most dually eligible beneficiaries, Medicare is the primary payer for services, while Medicaid covers cost-sharing amounts, such as co-payments and co-insurance. In order for providers to receive this cost-sharing payment from Medicaid, they need to be registered with the state Medicaid agency. However, providers may be hesitant to go through a lengthy Medicaid registration process if they do not serve Medicaid-only beneficiaries.

Description of the opportunity: States can encourage providers to enroll in Medicaid by creating a simplified registration process for them to enroll for the sole purpose of billing cost-sharing claims for dually eligible beneficiaries (also known as crossover claims). States may refer to this as “crossover-only” or “QMB-only” enrollment.[21] California and Vermont’s forms for crossover-only enrollment are particularly simple – just two pages – compared to 10 to 12 pages for the full physician enrollment form.[22]

How this opportunity supports integrated care: If a Medicare provider is not registered with Medicaid, it can complicate the process of seamlessly transferring a claim from Medicare to Medicaid for cost-sharing payment (also known as a crossover claim). In addition, if the provider is not registered with Medicaid, they will not be able to receive the Medicaid payment for cost-sharing and may resort to improperly billing the beneficiary for the remainder of the amount, an act which is prohibited by federal statute for certain types of dually eligible beneficiaries.[23] Facilitating provider enrollment in Medicaid can help to ensure that claims are seamlessly processed and paid by both Medicare and Medicaid. It can also improve beneficiary experience by protecting beneficiaries from being billed for benefits that are covered by Medicaid, and it can improve provider experience by preventing the administrative burden associated with correcting an occurrence of improper billing.

Implications for cost and administrative burden: States may find that adopting a simplified enrollment process for crossover-only providers reduces administrative burden by streamlining the crossover billing process and decreasing the time it takes to process lengthier enrollment applications. This process may

also reduce the occurrence of improper billing and reduce burden on providers who are attempting to enroll in Medicaid and receive payment for cost-sharing.

Conclusion

States can make administrative changes that will help them to provide more integrated care for dually eligible beneficiaries. Some of these changes are relatively low cost and involve little burden on states (e.g., offering prior authorization of DME coverage, allowing crossover-only Medicaid enrollment for providers). Other changes (e.g., executing a Part A buy-in agreement with CMS, increasing the frequency with which data are exchanged with CMS) may be more costly or require more state effort. By enacting the administrative changes described in this brief, states can build a stronger foundation for future Medicare-Medicaid integration efforts, and potentially improve beneficiaries' experience of care, decrease beneficiaries' out-of-pocket costs, and reduce provider burden.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the *Integrated Care Resource Center* are coordinated by **Mathematica Policy Research** and the **Center for Health Care Strategies**. For more information, visit **www.integratedcareresourcecenter.com**.

ENDNOTES

[1] Even DME items that Medicare does not cover will be denied, with the reason for denial coded as "non-covered."

[2] Centers for Medicare & Medicaid Services. "Strategies to Support Dual Eligible Beneficiaries' Access to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." January 23, 2017. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib011317.pdf

[3] Illinois updates its Medicaid DME fee schedule annually. For more information see: https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/DME.aspx

[4] California Department of Health Care Services. "Medicare Non-Covered Services: Charts Introduction." June 2001. Available at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/medinoncha_m00o02o03o04o06o07o08o11a02a04a05a06a07a08v00.doc and California Department of Health Care Services. "Medicare Non-Covered Services: HCPCS Codes." April 2018. Available at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/medinonhcp_m00o02o03o04o06o07o08o11a02a04a05a06a07a08p00v00.doc

[5] The MMA files are named after the Medicare Prescription Drug Improvement and Modernization Act of 2003. For additional detail on these files, see: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/StateMMAFile.html.

[6] Centers for Medicare & Medicaid Services. "How Much Does Part A Cost?" Available at: https://www.medicare.gov/your-medicare-costs/part-a-costs/part-a-costs.html

[7] Social Security Administration. "State Buy-In and Group Payer Provisions for QMBs." Available at: https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801140!opendocument

[8] State Medicaid agencies can obtain more information about entering into a Part A Buy-in Agreement by emailing statebuy-in@cms.hhs.gov with "Part A Payer Conversation" in the subject line. See also: Social Security Administration, Program Operations Manual System (POMS): HI 00801.140 State Buy-In and Group Payer Provisions for QMBs. Available at: https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801140

[9] Even in states with a Part A buy-in agreement, if an individual is not already enrolled in Part B, the individual will need to complete the conditional enrollment process.

[10] Conditional enrollment is a solution to the predicament faced by individuals who are ineligible for premium-free Part A but otherwise eligible to be a QMB. To meet requirements for QMB status, individuals must enroll in Part A but often cannot afford to enroll in Part A without the financial support of the QMB benefit. To address this, individuals may apply for Medicare Part A on the condition that the state will pay the premium without incurring liability. Once they have applied for Part A at the Social Security office, they can submit an application for QMB to the state Medicaid agency. If the individual is found eligible, the state pays the Medicare Part A premium; if not, the Medicare Part A conditional enrollment is dissolved and the individual continues without Medicare Part A coverage.

[11] Centers for Medicare & Medicaid Services. "Enrollment and Retention Flexibilities to Better Serve Medicare-Eligible Medicaid Enrollees." CMCS Informational Bulletin. January 23, 2015. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-23-2015.pdf

[12] For more information see: Medicaid and CHIP Payment and Access Commission. "Chapter 6: Effects of Medicaid Coverage of Medicare Cost Sharing on Access to Care." March 2015. Available at: https://www.macpac.gov/wp-content/uploads/2015/03/Effects-of-Medicaid-Coverage-of-Medicare-Cost-Sharing-on-Access-to-Care.pdf

[13] For more information on MSP and LIS eligibility, the National Council on Aging provides eligibility and coverage information. See https://www.ncoa.org/wp-content/uploads/medicare-savings-programs-coverage-and-eligibility.pdf and https://www.ncoa.org/wp-content/uploads/MSP-LIS-Asset-test-and-disregards.pdf.

[14] The Medicare Rights Center also provides information on MSP and LIS eligibility at https://www.medicareinteractive.org/pdf/MSPFinancialEligibiltyGuidelines.pdf and http://www.medicarerights.org/fliers/Help-With-Drug-Costs/Extra-Help-Chart.pdf?nrd=1.

[15] MIPPA sets this asset rule for QMBs, Specified Low Income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI), but not for Qualified Disabled Working Individuals (QDWI). See Pub. L. No. 110-275 § 112 (2008) (codified at 42 U.S.C. §1396d(p)(1)(C)). Available at: https://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf.

[16] The number using income limits higher than the federal standard varies depending on the source referenced. As of March 2018, eight states' MSP income limits are effectively higher than the federal income standards for the 48 contiguous U.S. states. Alaska and Hawaii have higher standards that are set by the federal government; Illinois and Mississippi list higher income standards than the federal standard because they use higher income disregards than the federal standard disregard; and Connecticut, Indiana, Maine, and Washington, D.C. set their own MSP income limits to be higher than the federal standards.

[17] National Council on Aging. "Medicare Savings Programs: Eligibility and Coverage." March 2018. Available at: https://www.ncoa.org/wp-content/uploads/medicare-savings-programs-coverage-and-eligibility.pdf

[18] See the following link for Colorado's MSP: https://www.colorado.gov/pacific/hcpf/medicare-savings-programs-msp. See the following link for New Jersey's MSP: http://www.state.nj.us/humanservices/doas/documents/MSP_bro.pdf

[19] See Georgia's MSP eligibility FAQs at https://medicaid.georgia.gov/medicare-savings-plans-programs-faqs. Georgia does not count life insurance with a cash value of $1,500 or less.

[20] For additional information on LIS and MSP data sharing opportunities, see "The Medicare Improvements for Patients and Providers Act: Improving Enrollment in the Medicare Savings Program Five Years Later." Available at: http://www.medicareadvocacy.org/the-medicare-improvements-for-patients-and-providers-act-improving-enrollment-in-the-medicare-savings-program-five-years-later/

[21] QMBs, or Qualified Medicare Beneficiaries, are a specific group of dually eligible beneficiaries who have their Medicare Parts A and B cost-sharing covered by Medicaid.

[22] California: http://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/Crossover_only.pdf and Vermont: http://www.vtmedicaid.com/assets/provEnroll/EnrollRevalMcareXoversOnly.pdf

[23] For billing prohibition for QMBs, see Sec. 1902(n)(3)(B) of the Social Security Act. For billing prohibition for non-QMB FBDEs in Medicare Advantage plans, see 42 CFR Sec. 422.504(g)(1)(iii). Additional information about prohibitions of balance billing see: Medicare Learning Network. "Prohibition Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program." SE1128 Revised. March 22, 2018. Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf