

**Current Processes for Enrolling
Medicare/Medicaid Dual Eligibles
in Medicare Savings Programs
and Efforts to Increase Enrollment**

**Prepared for the National Academy of Social Insurance
Study Panel on Medicare/Medicaid Dual Eligibles**

**Elizabeth Cusick and Ken Nibali
Independent Consultants**

July 2005

Table of Contents

I. Overview	4
II. Current Process	5
A. Medicare Enrollment	5
B. Medicaid Enrollment	6
C. Enrolling Dual Eligibles: Interaction of the Programs	7
III. Barriers to Enrollment	9
A. Lack of Beneficiary Awareness of the Programs	9
B. Beneficiary Limitations	9
C. Lack of Knowledge by Some Intake Workers in Handling Potential Beneficiaries	9
D. State Medicaid Office Setting	10
E. The Application	10
F. Asset Reporting	10
G. Systems Not Well Integrated at Federal, State, and Local Levels	11
IV. Current Efforts to Increase Enrollment	11
A. CMS/States	11
B. SSA Efforts	12
C. SSA Outreach Pilots	13
V. Implications of Current Processes for Enrolling Dual Eligibles	14
VI. References	17
Appendix I. Quick Reference Guide—Medical Care Program Coverage Groups and HealthChoice Eligibility, State of Maryland	18

Appendix II. State Medicaid Decisions.....	20
Appendix III. SSA Demonstration Projects	21

I. Overview

The Medicare program provides health insurance coverage for eligible aged and disabled persons. However, the design of the program requires payment of out-of-pocket costs by beneficiaries for cost sharing (premiums, coinsurance and deductibles) as well as for services not covered, most notably outpatient prescription drugs and most nursing home care. The Medicare Savings Programs (MSP) were enacted to provide low-income beneficiaries with assistance in meeting the out-of-pocket cost-sharing costs (not payment for the uncovered benefits). This paper looks at the processes for enrolling beneficiaries in these programs and some of the barriers, which have been identified as contributors to less than expected enrollment.

An examination of the current process requires one to look first at the Medicare and Medicaid enrollment processes separately and then at the interaction between the two. The process for enrolling dual eligibles is complex, involving two Federal agencies, State Medicaid agencies, and, in some jurisdictions, counties. The Social Security Administration (SSA) is responsible for eligibility determination for the Medicare program. The Centers for Medicare & Medicaid Services (CMS) is responsible for administration of the Medicare program and oversight of the joint Federal/State Medicaid program. States administer the Medicaid program either directly or, in some cases, in partnership with sub-state units such as counties.

There are a few basic differences between the Medicare and Medicaid programs that are useful to keep in mind as we look at current processes. In Medicare, as in Social Security's retirement and disability programs, eligibility is based on contributions based on earnings paid, over time, into the system. This means that for retirees, eligibility is determined only once and remains unchanged. For disabled persons, there is a possibility of change in eligibility, based on returning to work or an improvement in their medical condition.

Medicaid is a means-tested program, so part of the eligibility determination includes an examination of income and assets. These can change over time, thus requiring a regular redetermination to see if a person's eligibility continues. However, since disabled Medicare beneficiaries are less likely to work, their eligibility is less volatile than that of other categories of Medicaid beneficiaries.

Second, Medicare is a national program, with a single set of eligibility criteria fixed in Federal law and administered in a unified manner. Medicaid is funded jointly by the Federal and State governments, but the exact shape and details of the program are decided by States. There are some Federal requirements, but States have considerable latitude for expanding beyond those minimums. This means that programs vary across States both in scope and in methods of administration.

Third, funding sources for the two programs are different. Medicare has two parts with different funding sources. In general, Part A pays for hospital and other institutional services while Part B pays for physician and practitioner services, outpatient hospital

services, and other services such as durable medical equipment. Part A is funded by payroll taxes to the Hospital Insurance trust fund. Part B is funded in part (about 25%) through premiums paid by beneficiaries. The rest of Part B is paid from the general revenues of the Federal government. Medicaid is jointly funded by the Federal government and States. The exact Federal share, known as the matching rate, is determined by formula, but it ranges from 50 % to 76% and is paid from general revenues.

Fourth, Medicare and Medicaid do not provide the same benefits. Medicare primarily pays for services associated with acute illness. Although some preventive benefits are now included, most are not. Medicare does not currently pay for most prescription drugs, although Congress has recently enacted a prescription drug benefit which will begin in 2006. Medicaid does cover most preventive services and, in many States, provides a rich prescription drug benefit. Medicaid also pays for long term care, while Medicare covers limited long-term care services. In the case of dual eligibles, Medicare is the primary payer, so Medicare pays for anything it covers before Medicaid. Full Medicaid pays for the Part B premium, coinsurance and deductibles and any additional Medicaid benefits. Because Medicare is the first payor, States have financial incentives to ensure that any Medicaid beneficiary eligible for Medicare is enrolled.

II. Current Process

A. Medicare Enrollment

The Medicare enrollment process is conducted by the Social Security Administration. A Social Security application on the basis of age or disability is also an application for Medicare, and Medicare enrollment automatically follows entitlement to Social Security benefits. Individuals who decide to delay their retirement beyond age 65 must make a separate application for Medicare at age 65 in order to be enrolled. When people apply for Social Security benefits, they must provide SSA with their Social Security number, birth certificate, and information on their earnings for the last year. Entitlement is based on taxes paid by the worker and his/her employer over the worker's lifetime. SSA has a record of lifetime-covered earnings, which is used to compute the benefit. People can begin receiving retirement benefits as early as age 62. However, Medicare benefits do not begin until a person is age 65 or has been disabled for 24 months.

For many people, there is a substantial delay between applying for Social Security and receiving Medicare. Approximately 75 percent of retirees file before age 65 or are disabled individuals who have a 24-month waiting period. SSA keeps Medicare Part A and Part B accounting information as part of each individual's electronic Social Security record. Most individuals choose to pay their Part B premium through monthly deductions from their Social Security benefits.

Because of the delay between collecting benefits from SSA and eligibility for Medicare, CMS has a process for contacting and updating information from these beneficiaries as they near Medicare eligibility. This process is carried out by the coordination of benefits contractor, currently Group Health Incorporated (GHI). Based on information provided by SSA, GHI sends an initial enrollment package to each Social Security beneficiary three months before his or her expected date of entitlement. This package includes a copy of the *Medicare and You* handbook, other information about Medicare, and asks for information about other health insurance coverage, which can be used to make sure that any bills are appropriately allocated between Medicare and other insurers. The *Medicare and You* handbook includes information about the MSP program, including contact information for each State. It also includes contact information for State Health Insurance Program (SHIP) agencies.

B. Medicaid Enrollment

Enrollment in State medical assistance (Medicaid or any other medical assistance programs) can vary somewhat from state to state, but the basic outlines are consistent. An individual must apply, sometimes in person, at an office, often a welfare office. In the case of individuals who are eligible because they receive SSI benefits, application may be made in a Social Security office. In either case, people must provide information about their income and assets to see if they meet the guidelines set by the State program. People come into such offices without specific knowledge about what programs are available, so many States have computer-based systems that help collect information and figure out which programs would best meet the person's needs. Appendix I contains a sample of a State checklist (in this case the sample is from Maryland), which represents all the possible avenues by which a person might qualify for state benefits. The checklist is a good illustration of just how complex a determination this can be for states and the challenge it presents to intake workers.

Once a person is receiving benefits, States must periodically reexamine income and asset levels to see if they have changed in a way that might render a person ineligible. This redetermination process is similar to the initial one and usually includes filling out a new form. In some States, it may require a face-to-face encounter with a State worker. A Social Security claimant who is approaching age 65 or who claims disability is routinely screened by SSA for potential SSI eligibility. This screening of low-income individuals is required under the Code of Federal Regulations (20 CFR 416.350) and serves as a protective filing for individuals for SSI. Since SSI benefits can only be paid from the date an individual files for benefits, it is important to document that date (i.e. a protective filing) to establish from when benefits can be paid. As required under Section 1902 (a)(10) of the Social Security Act, coverage under SSI carries with it Medicaid eligibility. However, the relationship between SSI eligibility and Medicaid is not as close as that between Social Security eligibility and Medicare. States may choose to follow the federal SSI rules to qualify their aged, blind, and disabled for Medicaid, or they can choose an alternate approach. (See Appendix II for a list of how each state is handled).

SSA has agreements with 32 states and DC to make Medicaid eligibility decisions for those individuals found eligible for SSI. In those States, an SSI award of benefits is almost always a Medicaid award as well. In another 7 States (and the Commonwealth of the Northern Mariana Islands), Medicaid eligibility for individuals filing for SSI is still determined using federal SSI rules, but the individual must file a separate Medicaid application with their State Medicaid Agency. SSA staff routinely refer SSI beneficiaries to Medicaid state agencies to file an application, but SSA estimates that 10-20 percent of this group do not follow through on applying for Medicaid or they wait until a crisis develops before doing so. In addition to referring SSI beneficiaries to the State, SSA routinely makes available to all States information on all individuals who have been awarded SSI benefits, as well as any other changes to the SSI rolls. This is mainly done through the State Data Exchange system, or SDX.

The final 11 States use more restrictive criteria for Medicaid eligibility than the SSI rules (though by law not more restrictive than those in effect in approved 1972 state plans), and thus separate applications must be made by individuals to those states' Medicaid Agencies. Again, SSA estimates that 10-20 percent of these individuals do not follow through on their applications.

Finally, SSA also routinely refers to State Medicaid Agencies all SSI claimants who are found ineligible and those who become ineligible over time. In any notice of denial of benefits, SSA routinely informs the individuals to consult with their state agencies for other benefits, and provides information about these individuals to the states through the SDX system.

C. Enrolling Dual Eligibles: Interaction of the Programs

There are two basic paths for interaction between the Medicare and Medicaid programs depending on which one touches the beneficiary first. Individuals who come into state Medicaid offices seeking assistance will be screened for MSP eligibility and to be certain that, if they qualify for Medicare, they are receiving it. For people who are 65, it is relatively easy to recognize the potential for eligibility for Social Security if they have not already applied. The situation with disabled beneficiaries is more complicated because they must wait 24 months after qualifying for Social Security disability benefits before they are eligible for Medicare. Thus, many low-income disabled beneficiaries will receive some form of State assistance during this period. However, once the waiting period is over, they will automatically be added to the Medicare rolls. The States have a clear financial incentive to be aware of the status of these beneficiaries and to ensure that they buy-in to Medicare Part B whenever they can.

Individuals who apply for social security benefits and are automatically entered for Medicare coverage are also screened for SSI and Medicaid coverage. As discussed above, in those 32 states where SSA makes the Medicaid eligibility decision they also identify the state as the payer for Medicare premiums, so in essence they are making the MSP eligibility decision and triggering coverage.

However, in the other 18 states where a separate application is needed with the state for Medicaid coverage, it is up to the individual to follow through with their application and then for the state to make a decision regarding Medicaid/MSP eligibility as part of their screening process.

Individuals with income exceeding the SSI limits may be eligible for the MSP. Since SSA sees the vast majority of individuals who become entitled to Medicare, and screens them for SSI/Medicaid eligibility, it would appear to be in an ideal position to identify those eligible for the Medicare Savings Programs. However, the key difficulty is that the majority of individuals entitled to Medicare are not actually enrolled in Medicare until some time after SSA sees them, as discussed above. Thus, SSA is not generally in a position to know whether or not a person is still eligible for MSP when he or she is enrolled in Medicare. Unless SSI is involved, SSA has no need to develop or maintain information about income or resources, which are subject to change over time. Updating and maintaining this information is difficult and expensive and SSA does not receive specific funding for this activity.

This suggests that, among those eligible for the MSP, the most difficult group to enroll are those who have enrolled for Medicare but have not come into contact with the State systems which could enroll them in MSP. An evaluation by RTI International looked at differences between eligibles who have enrolled and those who have not. The data show that individuals with health problems are more likely to enroll and that enrollment is often precipitated by a major health event, especially hospitalization. This is consistent with the fact that hospitals have a financial incentive to ensure that patients take advantage of all possible insurance so that the hospital can be reimbursed. The RTI evaluation also showed that the vast majority of nonenrollees are unaware of the programs. According to RTI (p7) "If beneficiaries have heard of the programs, they do not enroll because they do not know how to apply or they assume they will not qualify for them."

III. Barriers to Enrollment

Various studies and efforts over the last few years have identified a number of key reasons for many eligible individuals not participating in the MSP. These reports include: (1) the National Senior Citizens Law Center's December 2002 report on "Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs Case Study Findings," (2) the RTI International October 2003 report on "Evaluation of Qualified Medicare Beneficiary and Specified Low-Income Medicare Beneficiary Programs," (3) the Barents Group's April 1999 report on "A Profile of QMB-eligible and SLMB-eligible Medicare Beneficiaries," and (4) the results of the 1999 effort "Reach Out- A Cooperative Effort by Stakeholders to Enroll Dual Eligibles."

A. Lack of Beneficiary Awareness of the Programs

Despite the many efforts of government agencies, health organizations, advocate groups, etc., many individuals apparently are either not aware of the MSP or believe they are not eligible. Some of this involves people who have a low level of contact with the health system (until a crisis arrives) and therefore have not had as great a chance of being informed of the programs. In particular, individuals with limitations such as language, literacy, or vision/hearing problems are more likely not to know how to apply for the programs or assume they won't qualify. Even some of the beneficiary advocacy organizations are not well informed about the programs and thus are not readily able to help individuals understand them and apply for benefits. For individuals who are comparatively better off, there is evidence that they do not necessarily see the potential benefits of the programs outweighing the perceived difficulty of applying or making public their personal information.

B. Beneficiary Limitations

Many of the individuals in the population eligible for MSP have limitations that make it more difficult to reach them and communicate with them in an effective manner. Factors cited in the studies include inability to speak English, extreme age, lower levels of literacy, increased vision and hearing difficulties, and transportation problems that make it difficult to travel to state offices for help.

C. Lack of Knowledge by Some Intake Workers in Handling Potential Beneficiaries

This includes the lack of knowledge on the part of some intake workers as to the programs themselves and the many detailed aspects involved in qualifying. While generally the concern here is about some state Medicaid office workers, the same concerns exist about workers in community and advocacy organizations, as well as in other state offices (such as Offices on Aging) where workers are not as familiar with the MSP but are approached by individuals in need of help. The lack of knowledge is

sometimes tied to insufficient training. Beyond lack of knowledge, high caseloads have been cited as sometimes contributing to intake workers not having the time to fully explore with beneficiaries all of their rights under the MSP.

D. State Medicaid Office Setting

Many states have had a requirement for face-to-face applications for Medicaid/MSP benefits, meaning that individuals must personally appear at the state Medicaid offices. Besides of the problems mentioned above regarding transportation or health issues, some people have a concern with the “welfare stigma” associated with applying for MSP benefits at the state office. This problem can be exacerbated by the lack of out stationing sites for conducting state business. As discussed in section IV below, a number of states have made changes that have created options for beneficiaries to apply for MSP benefits other than at traditional welfare offices.

E. The Application

The process and forms for applying for MSP benefits can be, or at least are often perceived to be lengthy, complex, and cumbersome. Many states use their full Medicaid application forms to take applications for the MSP, which adds to the perceived level of difficulty for many applicants. Of course, the nature of the programs and the information needed to establish income and asset levels make it both a lengthy and seemingly intrusive process regarding personal information. Again, as discussed in section IV, states have made a number of changes to simplify their application processes, although beneficiaries continue to find them burdensome, particularly regarding disclosure of assets.

F. Asset Reporting

As just discussed, asset reporting can be seen as difficult and complicated. The fixed level of assets allowed for qualifying for the MSP is seen as increasingly restrictive and causes a number of potential beneficiaries to assume they won’t qualify. There are two tests for financial eligibility. The first compares income to a standard related to the Federal poverty level. Because the Federal poverty level is re-computed annually, the income limits change every year to reflect inflation. The second limits the amount of resources or assets to \$4000 for an individual and \$6000 for a couple. These amounts, set in statute in 1989, have not changed over time and have, therefore, become more restrictive. Supplying the needed information is seen as burdensome to the applicants and it can be difficult for the intake workers to assess accurately.

A particular concern regarding asset reporting is estate recovery rules. Federal law requires states to seek recovery from the estates of Medicaid beneficiaries for payments for mandatory services, which include long-term care and associated hospital and

prescription drug services. In such cases, the States must also seek to recover payments for premiums and cost sharing. However, for people who have not received long-term care payments, States may, but are not required to, recover from estates. States may choose to exempt from estate recovery low-income beneficiaries who received assistance with premiums and cost sharing, that is, MSP participants. Often the most important asset in this context is a person's home, which is not counted in the asset test, but is included in the estate. Regardless of the rules each state actually follows, the perception of losing one's estate to the state if a person accepts MSP help is apparently a significant deterrent that keeps some individuals from seeking benefits.

G. Systems Not Well Integrated at Federal, State, and Local Levels

The sharing of information between government agencies as to the actual or potential eligibility of individuals for the MSP is a key part of reaching and enrolling these individuals. While improvements are ongoing to better integrate these information systems, more can always be done to improve the collective ability to identify and enroll the people in need of these programs.

IV. Current Efforts to Increase Enrollment

A. CMS/States

In response to concerns about under-enrollment, CMS has worked with the States to increase enrollment in the MSP. From 1999 to 2001, much of this activity was organized and measured as part of a Government Performance and Results Act (GPRA) goal.

- In Fiscal Year 1999, an enrollment baseline was developed to serve as a basis for comparison. The baseline is the number of dual eligibles enrolled as of September 1998. CMS also contracted with the American Public Human Services Association (APHSA) to survey States about their activities.
- The 2000 goal was to increase enrollment by 4 percent, double the historical growth rate. This goal was exceeded; the actual increase was 4.4 percent.
- In 2001, five States received grants for outreach and enrollment activities and were expected to exceed the national growth rate. The national average was a 3.6 percent increase, and the five States had an average increase of 4.3 percent. Also in 2001, CMS contracted with APHSA to do a follow-up survey on State activities.

In its revised performance plan for 2002, the new Administration discontinued the GPRA targets for increased enrollment in the Medicare Savings Programs. Instead, it established a new performance goal of increasing beneficiaries' awareness of the programs, as measured by responses to a question in the Medicare Current Beneficiary Survey (MCBS). This goal was itself discontinued in 2005.

In its report on GPRA performance in FY 2001, CMS cataloged a wide variety of activities that the States used to accomplish this improvement. In almost all cases, the number of States reporting each activity has increased from the base period. Almost all States report use of a wide variety of outreach materials and methods. These include:

- 34 States use printed materials, primarily pamphlets explaining the MSP.
- 29 States mailed materials directly to potential beneficiaries identified through information from the Federal government or State data.
- 40 States do in-person presentations at health fairs or other appropriate gatherings.
- 35 States provided special training for people who might come in contact with potential beneficiaries such as State staff, Medicaid providers, and community health advocates.
- Almost all States reported partnerships with other state agencies, most often State or local aging units or State Health Insurance Programs (SHIPs), and other groups such as health care delivery organizations and grass roots organizations.

Beyond outreach efforts, States have moved to simplify the application and enrollment process. The Benefits Improvement and Protection Act (BIPA) of 2000 required HHS to develop a simplified national application form for States, at their option, to use for MSPs. The form was developed in partnership by CMS working with State Medicaid staff. The final product is available at www.cms.hhs.gov/dualeligibles/modelapp.asp. The CMS GPRA report shows that thirty-three States used a shortened form and ten more were in the process of moving to a shortened form or already had a short form.

Most States (42) do not require beneficiaries to go to a social services office for an in person interview either for initial applications or redeterminations. Instead, they allow mail-in application or provide alternative sites. States are also modifying their redetermination processes to make them less burdensome. Over half the States (27) have an automatic redetermination process in place for the MSP beneficiaries.

The area in which there has been the least change is financial eligibility determination, the assessment of resources and assets to determine whether the means test is met. States have flexibility to create financial eligibility policies that are more generous than those employed by SSI. They can increase income disregards or eliminate consideration of assets altogether. However, these kinds of changes would require action by State legislatures and involve countervailing incentives. On one hand, removing the assets test or allowing self-attestation of resources is an administrative simplification, which would reduce demand on State employees. However, more generous standards would potentially increase State costs by allowing more people to receive the benefit. An analysis of the effect of simplified asset tests in Arizona found that benefit costs were roughly offset by administrative savings.

B. SSA Efforts

Despite limits in funding, SSA conducts a number of efforts on the behalf of potentially eligible MSP individuals as part of its general public service responsibilities. These low-cost efforts include:

1. Incorporating information about the programs in SSA publications, handouts, and fact sheets that can reach targeted individuals and the organizations that assist them.
2. Advertising the MSP in annual check stuffers and COLA notices.
3. Having specific instructions in SSA field office operating manuals for public contact employees to make referrals to Medicaid offices of potential dual eligibles.
4. Making available to SSA's toll-free telephone staff instructions and automated screens to direct callers to appropriate Medicaid offices.

BIPA instructed SSA to annually identify potential MSP eligibles, notify them about the programs, and send a copy of the list of the identified individuals to the appropriate states. (This provision became section 1144 of the Social Security Act.) Because of the limitations of SSA's data on individuals' incomes and resources, this effort resulted in a large number of mailings (about 16.5 million) to potential eligibles in 2002. An additional 4.25 million letters were sent in 2003 to newly eligible individuals and those with income changes and about 20 percent of those who received a letter the prior year. For Fiscal Years 2004 and 2005, approximately 24 million mailings will be sent each year, with most of the increase above FY 2003 levels due to the need to provide information about Medicare drug discount cards. In fiscal years 2006 and beyond about 6 to 7 million mailings are planned per year.

A recently released report by the General Accounting Office evaluated the results of the first year's effort under the mailings. GAO estimated that more than 75,000 additional eligible beneficiaries enrolled in the Medicare Savings Program than would have registered without the letters. They noted that CMS enrollment data also showed that growth in MSP enrollment the year after the mailings was nearly double that of any of the previous 3 years. Beneficiaries less than 65 years old, persons with disabilities, racial and ethnic minorities, and residents in southern states had higher enrollment rates than other groups.

When beneficiaries are receiving some form of State medical assistance before they become eligible for Medicare, either by reaching age 65 or meeting the Title II disability criteria, the States have a strong incentive to recognize the potential for Medicare enrollment. Usually it is cost effective for the State to buy in to Medicare Part B for eligible beneficiaries. There is a mechanism for States to electronically check with the Federal government to see if any of their beneficiaries are already receiving Medicare. Most States also ensure that beneficiaries file for Medicare benefits when they are able to do so.

C. SSA Outreach Pilots

Given the general level of concern over the underutilization of the MSP, Congress directed in the 1999 Omnibus Consolidated and Emergency Supplemental Appropriations Act (Public Law 105-277) that SSA undertake federal/state partnerships to evaluate means to promote participation in the MSP and included \$6 million in SSA's budget for the effort. From March 1999 through February 2001, SSA tested 8 different models to reduce these barriers to enrollment:

- Lack of knowledge about the programs,
- The “welfare office stigma,” and
- Resistance to filing.

Sixteen States formed partnerships with SSA to test the models. (See Appendix III for a complete list of models, states, and summary results). One and a half million letters were delivered to Medicare beneficiaries in the participating 16 states. When beneficiaries responded, the major types of processes tested for effectiveness were:

1. Screening where the beneficiary calls a special SSA number and is screened for buy-in eligibility and then referred to local Medicaid office for processing;
2. Co-location where after SSA screening the referral is made to a Medicaid employee out stationed in the SSA office;
3. Application where after screening SSA takes the buy-in application and forwards it to the Medicaid office;
4. AARP assistance where the outreach letter requests beneficiary to contact an AARP representative to help them through the application process; and
5. Decision-making where SSA makes the eligibility decision (subject to Medicaid office quality control).

Overall the SSA demonstration efforts increased MSP enrollments in the test areas by about 7 percent. However, an independent evaluator for SSA, the Lewin Group, projected a national increase of up to 10 percent in enrollment based on the model selected. Generally, there was greater participation through the system and into the buy-in programs as the amount of SSA involvement with the enrollment process increased. The application model, where SSA not only conducted the screening but also took the application and made sure it got to the Medicaid office, had the best results, with an additional 26 people enrolled per 1,000 letters sent (compared to an additional 17 people enrolled per 1,000 letters sent for the demonstrations as a whole).

V. Implications of Current Processes for Enrolling Dual Eligibles

Since it is the responsibility of the States, including the 32 states where SSA determines eligibility for Medicaid, to enroll individuals in the MSP, the key to the current process for getting these individuals into the system is getting them in touch with the state Medicaid program so the states' screening mechanisms can do their job to identify and enroll the eligible individuals. There are clearly some categories of individuals for whom the current process works well.

For the 32 states and DC where SSA makes a Medicaid enrollment decision for SSI recipients, the states have direct information on these individuals and can make the determination as to their MSP eligibility as part of their Medicaid coverage. Most of these individuals are quickly identified and receive benefits appropriately. States are receiving a validated set of information from a reliable source, SSA. To the extent this process doesn't always work, reasons may include the lack of understanding/training on the part of some SSA/state employees as to specific MSP requirements, or workload pressures that mean all leads are not followed.

For the other 19 states/territories where SSA enrolls SSI recipients but the individuals must make separate application to the states for Medicaid, there is still the advantage of the states knowing of these individuals and their potential eligibility for the MSP. States can take appropriate follow-up action if the individuals do not pursue Medicaid coverage on their own. In addition, SSA refers information to the states on individuals who apply for SSI but are not eligible, but who have marginal incomes and may be eligible for MSP coverage.

For those individuals who go directly to the states to seek assistance, the states have screening mechanisms to determine Medicare coverage and then if full Medicaid or at least MSP apply to the individual. Again, however, the lack of training/understanding on the part of some employees can mean all leads are not followed through.

Data from the RTI evaluation suggests that individuals who come into contact with medical institutions, e.g. hospitals, or have a costly medical event are more likely to enroll as dual eligibles. Their data showed that "hospitalization was the most common precipitating event to enrollment." (p75) This suggests that institutions, in particular, have resources to help beneficiaries enroll in these programs when they are facing large bills. This makes sense because the institution is also helping to insure that its costs will be reimbursed.

While we can identify categories of beneficiaries for whom the system works, it is harder to categorize those who are not enrolling.

Although all dual eligibles must be enrolled by SSA as Medicare beneficiaries, there is often a delay between SSA's initial actions and when most of those individuals actually enter the rolls. Thus, SSA is limited in its opportunity to look for MSP eligibility at the time of Medicare enrollment because information on income and resources collected at that time may have changed and must be re-validated. For the 19 states/territories where SSI beneficiaries must file a separate Medicaid application with the state, there is no guarantee that the applicant will follow through with the State.

The primary problems are that many eligible individuals do not know about the programs, do not fully understand the programs, or are resistant to filing for the programs. Although States have improved their efforts, not all States are using all identified best practices. In addition, some of the non-enrollees have special needs

because of their age, disability, or language barriers. In particular, people are concerned about losing property based on state efforts of asset recovery - an area of much misunderstanding. Efforts discussed above to have simplified applications and better trained staff are aimed at addressing some of these concerns, but some individuals continue to find, or at least perceive, the process to be difficult to navigate. Evaluations and the SSA demonstration project suggest that individuals need hands-on assistance to fully understand the programs and be able to complete the applications. An overall continuing problem is the lack of good, current data on Medicare beneficiaries' income and assets so that mailings and other outreach efforts can be better targeted to those eligible for MSP but not enrolled.

VI. References

Barents Group. A Profile of QMB-Eligible and SLMB-Eligible Medicare Beneficiaries, prepared for the Health Care Financing Administration. April 1999.

Centers for Medicare & Medicaid Services. Performance on the Government Performance and Results Act (GPRA) Measure to “Improve Access to Care for Elderly and Disabled Medicare Beneficiaries Who Do Not Have Public Or Private Supplemental Insurance”. April 2002.

Glaun, Kim, National Senior Citizens Law Center. Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs Case Study Findings, prepared for The Kaiser Commission on Medicaid and the Uninsured, December 2002.

Haber, Susan G., et al, RTI International. Evaluation of Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs, prepared for the Centers for Medicare & Medicaid Services, October 2003.

Lewin Group. Results from the SSA Buy-In Demonstration, prepared for the Social Security Administration, October 4, 2001.

Shaner, Heidi. Dual Eligible Outreach and Enrollment: A View from the States, Report submitted by the American Public Human Services Association to HCFA, March 1999; available from www.cms.hhs.gov/dualeligibles/oereport.pdf.

Streett, Craig. SSA and Dual Eligibles, prepared for the NASI panel on Dual Eligibles, October, 2003.

U.S. General Accounting Office. Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment, Washington. GAO/HEHS-99-61, April 1999.

U.S. General Accounting Office: Results of Social Security Administration’s 2002 Outreach to Low Income Beneficiaries, Washington. GAO/HEHS-04-363, March 2004.

Appendix I. Quick Reference Guide—Medical Care Program Coverage Groups and HealthChoice Eligibility, State of Maryland

Family & Children (FAC)

- *F01 TCA Recipients – Section 1931 - Cash
- *F02 Post TCA Earnings Extension
- *F03 Post TCA Child Support Extension
- *F04 FAC Non-MA Requirement
- *F05 FAC – Section 1931 – Non-Cash
- *F98 FAC - Medically Needy
- F99 FAC – Spenddown

Pregnant Women & Maryland Children's Health Program (PW/MCHP)

- *P02 Pregnant Women up to 185% FPL
- *P03 Newborns
- *P06 Child under 1 year old, up to 185% FPL
- *P07 Child 1 up to 6 years old, up to 133% FPL
- *P08 Child under 19 years old, up to 100% FPL
- +P10 Family Planning Program services only
- *P11 Pregnant Women 185%-250% FPL
- *P12 Newborns of P11 Mothers
- *P13 Title XXI MCHP, Child under 19 years old, up to 185% of FPL

Maryland Children's Health Program (MCHP) Premium

- *+P14 Title XXI MCHP, Child 185%-200% FPL (P14 under MCHP Premium effective 9/1/03)
 - +D01 Employer Sponsored Insurance (ESI) (D-track closed to new enrollees 7/1/03)
- *+D02 HealthChoice, 200% - 250% FPL
 - +D03 Employer Sponsored Insurance (ESI)
- *+D04 HealthChoice, 250% - 300% FP

Foster Care and Adoptions

- *E01 IV-E or SSI, Adoption & Foster Care
- *E02 Non-IV-E Foster Care & Special Needs Subsidized Adop.
 - E03 State Funded Foster Care
 - E04 State Funded Subsidized Adoption

Refugees

- *G01 Refugee Cash Assistance (RCA)
- *G02 Post RCA Earnings Extension
- *G98 Refugee Medical Assistance, Non-Spenddown
- G99 Refugee Medical Assistance, Spenddown coverage group

Home & Community Based Waivers & PACE

- *H01 HCB Waiver and PACE
- *H98 HCB Waiver Medically Needy

Aged, Blind & Disabled (ABD) and State Programs

- *S01 Public Assistance to Adults (PAA)
- *S02 SSI Recipients
 - S03 Qualified Medicare Beneficiaries (QMB)
- *S04 Pickle Amendment
- *S05 Section 5103

- S06 Qualified Disabled Working Individuals
- S07 SLMB I
- +S08 SLMB I/MPAP
- +S09 Maryland Pharmacy Assistance Program (MPAP)
- +S10 QMB/MPAP
- +S11 TEMHA/MPAP
- +S12 Family Planning Program/MPAP
- +S13 Administrative
- S14 SLMB II (QI-1)
- +S16 Maryland Pharmacy Discount Program (MPDP)
- +S17 MPDP/SLMB I
- +S18 MPDP/SLMB II
- *S98 ABD – Medically Needy
- S99 ABD – Spenddown

Family Long Term Care

- T01 TCA Adult or Child in LTC
- T02 FAC Child in LTC Medically Needy
- T03 MCHP Child Under 1 in LTC (P06 standards)
- T04 MCHP Child Under 6 in LTC (P07 standards)
- T05 MCHP Child Under 19 in LTC (P08 standards)
- T99 FAC LTC Spenddown

Aged, Blind and Disabled Long Term Care

- L01 SSI Recipient in LTC
- L98 ABD Long Term Care
- L99 ABD Long Term Care Spenddown

Women's Breast and Cervical Cancer

- +W01 Women's Breast and Cervical Cancer

Aliens

- X01 State Only Aliens—children & pregnant women (MCHP standards)
- X02 Illegal & Ineligible Aliens (emergency medical services only)

- * HealthChoice eligible unless on Medicare, living in an institution, waiver code of MOD or MWD for model waiver, or living out of state.
- + Not on CARES; on MMIS only

SOURCE: State of Maryland, version of November 2003.

Appendix II. State Medicaid Decisions

Sec. 1634 States (33)

[Agreement with SSA;
Application for
SSI and Medicaid]

Alabama
Arizona
Arkansas
California
Colorado
Delaware
District of Columbia
Florida
Georgia
Iowa
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Mississippi
Montana
New Jersey
New Mexico
New York
North Carolina
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Vermont
Washington
West Virginia
Wisconsin
Wyoming

SSI States (8)

[SSI Rules;
Separate State
Application]

Alaska
Idaho
Kansas
Nebraska
Nevada
Northern Marianna Islands
Oregon
Utah

Sec. 209(b) States (11)

[More Restrictive
Than SSI; Separate
Application]

Connecticut
Hawaii
Illinois
Indiana
Minnesota
Missouri
New Hampshire
North Dakota
Ohio
Oklahoma
Virginia

Appendix III. SSA Demonstration Projects

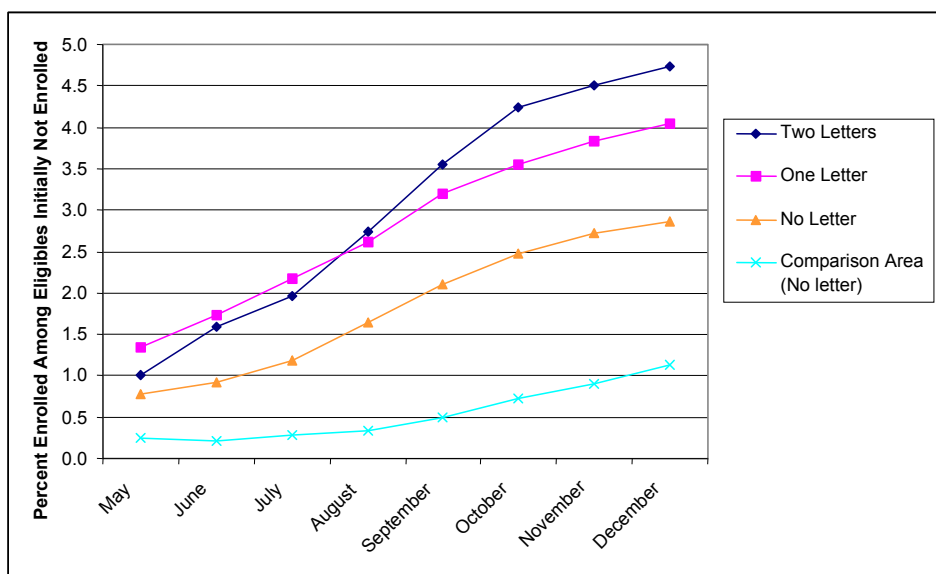
Examples of SSA Demonstration Results

Additional Enrollment per 1,000 Letters Mailed

Model/Site	Additional Enrollment per 1,000 Letters
Screening	18
Co-Location	20
Application	26
AARP Assistance	7
<i>Excluding Asheville, NC</i>	10
Decisionmaking	18
<i>Excluding San Francisco, CA</i>	22
TOTAL	17

Source: The Lewin Group analysis.

Rate of Monthly Enrollment in Buy-in by Number of Letters Sent to Beneficiaries in San Francisco



Source: The Lewin group analysis of the MBR letter file and a supplemental file identifying those not sent letters from SSA and Third Party Billing data from CMS.

SSA Part B Buy-in Demonstration Models

MODEL TYPE	DESCRIPTION
Screening	Outreach letter, modest publicity. Beneficiary calls special SSA number for buy-in eligibility screening. Handoff of potential eligibles to local Medicaid office. (1999)
Co-Location	Outreach letter, modest publicity. Beneficiary calls special SSA number for buy-in eligibility screening. Handoff of potential eligibles to Medicaid employee outstationed in SSA office. (1999)
Application	Outreach letter, modest publicity. Beneficiary calls special SSA number for buy-in eligibility screening. SSA takes buy-in application in an SSA office and passes to Medicaid office for a decision. (1999)
Widow(er)s	When beneficiary contacts SSA to report spouse's death, SSA requests buy-in eligibility screening. Outreach letter soliciting a call to special SSA number if funeral director reports death and widow(er) may be eligible. Handoff of potential eligibles to local Medicaid office. (1999-2000)
AARP Assistance	Outreach letter requesting beneficiary to contact an AARP volunteer at a special number for Federal benefits eligibility screening. AARP assists potentially eligible beneficiary through the application process. (1999)
Decisionmaking	Outreach letter, modest publicity. Beneficiary calls special SSA number for buy-in eligibility screening. SSA takes buy-in application in an SSA office and makes eligibility decision (subject to quality control review in Medicaid office before implementation). (2000)
Decisionmaking with Publicity	Outreach letter with high profile, professional multilingual publicity. Beneficiary calls special SSA number for buy-in eligibility screening. SSA takes buy-in application in an SSA office and makes eligibility decision (subject to quality control review in Medicaid office before implementation). (2000)
AARP Mailing	Outreach packet with letter from SSA, AARP eligibility guide, State evidentiary requirements and State buy-in application. Beneficiary uses written materials to self-screen and sends application (or request for additional information) using postpaid envelope back to SSA (for counting) and then forwarded to appropriate Medicaid office. (2000-2001)

State Partners in the SSA Buy-in Demonstration

1999 Demonstration		2000 Demonstration	
SSA Models	AARP Assistance	SSA Models	AARP Mailing
Florida	California	California	Arkansas
Indiana	Missouri	Massachusetts	Kentucky
Kentucky	Nebraska	Pennsylvania	Missouri
Massachusetts	North Carolina	Texas	New Hampshire
Oklahoma	Pennsylvania		North Dakota
Pennsylvania			Oregon
Texas			Washington

State Partners by Model

Model	State	Location
Screening	Pennsylvania	Carlisle, Lebanon
Co-Location	Oklahoma Pennsylvania	Muskogee, Oklahoma City Uniontown, West Chester
Application	Florida Indiana Kentucky Texas	Miami, Orlando Evansville Lexington Corpus Christi
Widow(er)s	Massachusetts	Entire State
AARP Assistance	California Missouri Nebraska North Carolina Pennsylvania	Los Angeles St. Louis Omaha Asheville Pittsburgh
Decisionmaking	Pennsylvania Texas	Philadelphia Dallas, San Antonio
Decisionmaking with Publicity	California	San Francisco
AARP Mailing	Arkansas Kentucky Missouri New Hampshire North Dakota Oregon Washington	Entire State Louisville 5 counties Entire State Entire State Specific areas Specific areas