

## **An Investigative Report on Medicare Savings Programs in New York City: Local Involvement in Federal Programs Impedes Access for People with Low Incomes**

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A REPORT BY MEDICARE RIGHTS CENTER

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### **Executive Summary**

Health care costs are becoming increasingly unaffordable for people with Medicare. A typical person with Medicare spends approximately 22 percent (1) of her annual income to pay for health care costs each year, up from 19 percent in 1999. Medicare supplemental insurance coverage and Medicare HMOs are becoming more expensive, as are non-covered health care services like prescription drugs and long-term care.

For low-income people with Medicare, the situation is particularly bleak. People with low incomes tend to be in poorer health than higher income people with Medicare and spend more of their income to pay for their care.(2) Those living below the poverty level spend over a third of their annual income (35 percent) on out-of-pocket health care costs.(3) People with Medicare in New York are more likely to need financial assistance to pay for health care than those in most other parts of the country as New York State has a higher percentage of older adults living in poverty than in the United States as a whole.(4)

To assist low-income people with Medicare in paying for their health care costs, Congress enacted two entitlement programs QMB, (Qualified Medicare Beneficiary) and SLMB, (Specified Low-Income Medicare Beneficiary) and two federal block grant programs QI-1, (Qualifying Individual 1) and QI-2, (Qualifying Individual 2) to pay for a range of Medicare cost sharing burdens. These programs are collectively called the Medicare Savings Programs (or the Buy-In Programs) and people with Medicare qualify for them based on income and asset standards. QMB covers an enrollee's Medicare Part B premium, coinsurance, and deductibles, while SLMB and QI-1 cover only the Medicare Part B premium (\$50 per month in 2001) and QI-2 covers only a portion of the Part B premium (\$3.09 per month in 2001.) The Medicare Savings Programs are considered valuable because, with the exception of QI-2, they save people with Medicare a minimum of \$600 a year. Unfortunately, the Medicare Savings Programs are significantly underutilized.

After receiving large numbers of calls over the last few years to Medicare Rights Center's hotline from people who have little to no awareness of the Medicare Savings Programs, and from those who have difficulty getting access to the Medicare Savings Programs, we engaged in a one-year study to identify the individual and systemic barriers that prevent people from enrolling in these programs in New York City. By tracking Medicare Rights Center (MRC) clients as they navigated through the Medicare Savings Program enrollment process, we were able to identify the key access barriers as well as develop recommendations to improve how the Medicare Savings Programs should be administered.

Inadequate outreach and education efforts are a leading cause of under enrollment as people with Medicare have a limited awareness that the Medicare Savings Programs exist.(5) For those who are familiar with them, other barriers often preclude them from getting the benefit. This report investigates the barriers people face once they try to enroll in a Medicare Savings Program.

Of the 104 people we tracked over our year-long project:

- 33 people did not apply because they were: not interested in the programs; reluctant to go to the Medicaid office; ill; or confused about the programs.
- 31 people tried to enroll in the Savings Programs: 19 were unsuccessful; 7 received the benefit, 3 after waiting almost a year; 5 had just applied at the end of our study.

- 24 were lost to follow-up because of: clients no longer returning MRC's phone messages; disconnected phones; or referrals to other agencies based on language needs and homebound status.
- 14 were ineligible for the programs because of: high income or assets; or unsettled financial situations.
- 2 died during the course of the study.

This report investigates the greatest barriers faced by people applying for the Medicare Savings Programs:

- **Those eligible find the Medicare Savings Programs confusing and the application process arduous.**

The programs have complicated names that do not identify their purpose such as QMB (Qualified Medicare Beneficiary,) and SLMB, (Specified Low-Income Medicare Beneficiary). Also people with Medicare are used to the automatic nature of Medicare that doesn't require any visit to a government agency, but applying for these programs requires at least two visits to the Medicaid office, including a face-to-face interview. Those applying for QMB are also required to fill out the eight-page Medicaid application.

- **People are reluctant to apply for the Medicare Savings Programs at a Medicaid office.** People with Medicare do not understand why they must apply for a Medicare program at a Medicaid office. Some people have had negative experiences at Medicaid offices in the past and refuse to go back.

- **Applicants have received incorrect information about applying for the Medicare Savings Programs from Medicaid branch office staff.**

Medicaid branch office staff make the assumption that people coming into the office are only there to apply for Medicaid. This assumption is perpetuated through the use of Medicaid intake sheets that omit the Medicare Savings Programs from the list of choices that can be selected as the client's "reason for visit." Some Medicaid branch office staff are unaware that the Savings Programs exist and neglect to screen clients for them. Others lack knowledge about which application forms to offer Medicare Savings Program applicants, and give out incorrect information about how long it takes to process an application.

- **Applications get lost and consumers have difficulty tracking an application as it moves through the processing system.**

Applications are processed through city, state, and federal agencies. Each agency functions in a vacuum with little understanding of the applications' prior or successive steps in the process. There is no well-publicized point person at each agency for consumers to contact to learn if their application is lost, or learn the current status of their application.

MRC staff faced an additional barrier while helping people enroll in the Medicare Savings Programs:

- **Government officials at the city, state, and federal level give out inaccurate information about how the applications are processed, and how to determine if someone qualifies for the benefits.**

MRC struggled to get accurate information about the protocol for administering the Medicare Savings Programs. MRC was given conflicting information about topics such as the time frame for an applicant to receive notice of his eligibility in the program, and about the income calculation to determine whether someone is eligible.

Based on our experience working with clients as they struggled to enroll in the Medicare Savings Programs, and through interviews with government officials ranging from representatives of New York City's Human Resources Administration to officials from the New York State Department of Health, Social Security Administration, and the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration,) we make the following policy recommendations to improve how the Medicare Savings Programs are administered:

## Federal-level Reforms

- **Administer the Medicare Savings Programs through the Social Security Administration.**

Having multiple government agencies involved in administering the Medicare Savings Programs creates an inefficient structure. Each agency has a compartmentalized function that limits its accountability for the entire administrative process and limits its knowledge about how the programs work. If the Medicare Savings Programs become fully federal programs and the Social Security Administration takes over their administration, much of the confusion between government agencies could be eliminated. Moving the program under federal auspices would shift costs from the states to the federal government. However, Congress already gives the Social Security Administration \$1 billion annually from the Medicare Part A Trust Fund for Medicare-related activities.<sup>(6)</sup> Congress should investigate whether some of these funds could be used to administer the Medicare Savings Programs.

On the road to federalizing the programs, there are other recommendations that could be implemented to increase enrollment.

- **Set national standards for administering the Medicare Savings Programs.**
- **Develop and disseminate a Medicare Savings Program guidebook that explains the enrollment process for all government agencies that administer or oversee the Savings Programs.**

## New York State/City-specific Reforms

- **Create and publicize a toll-free hotline for consumers to ask questions about applying for the Savings Programs, and to track the status of their application.**
- **Develop one computer system for the programs for the entire state.**
- **Create a simpler application form for enrollment in the QMB program.**
- **Eliminate the face-to-face interview requirement for all counties in New York State.**
- **Change Medicaid intake forms to include Medicare Savings Programs as a "reason for visit" option.**
- **Set training standards for local Medicaid branch office staff.**

1. Moon, M., Maxwell, S. and Segal, M. "Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries," The Commonwealth Fund, January 2001.

2. O'Brien, E., and Rowland, D., "Medicare and Medicaid for the Elderly and Disabled Poor," Kaiser Family Foundation: Kaiser Commission on Medicaid and the Uninsured, May 1999.

3. Ibid.

4. Medicare State Profiles. Henry J. Kaiser Family Foundation, September 1999.

5. Medicare Rights Center. "Making Health Care Affordable for People with Low-Incomes," Medicare Facts and Faces, Fall 2000.

6. Richard Chambers, Acting Deputy Director, Center for Beneficiary Services, CMS, Advisory Panel on Medicare Education meeting, April 26, 2001.

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## Background

For older and disabled people with Medicare, health care costs are becoming increasingly unaffordable. Prescription drug prices are rising, and premium costs for Medicare supplemental insurance policies are increasing by 10 percent a year.<sup>(7)</sup> Costs associated with managed care plans are also rising; in 2000 premiums for Medicare HMOs nearly doubled from those in 1999.<sup>(8)</sup> Medicare has significant cost-sharing requirements causing older and disabled people with Medicare to incur substantial out-of-pocket health care costs. A typical person with Medicare spends approximately 22 percent of her annual income, or \$3,142, to pay for health care costs each year. <sup>(9)</sup>

Low-income people with Medicare face a bleaker situation.<sup>(10)</sup> Those living below the federal

poverty level spend 35 percent of their annual incomes on out-of-pocket health care costs and 44 percent report fair or poor health compared to 20 percent of those with higher incomes.(11) Nearly one in six (16 percent) of Medicare's poor and near-poor have neither private nor public supplemental coverage and rely solely on Original Medicare, and only 8 percent of the poor and 25 percent of the near-poor have retiree health benefits.(12) Add to these statistics soaring health care costs and a lack of coverage for prescription drugs and long-term care, and a clear picture of the heavy financial burden facing low-income people with Medicare emerges.

Medicare Parts A and B provide insurance that covers some of the costs of hospital services, skilled nursing care, home health and hospice care, and doctors' services but have cost-sharing requirements that include premiums, deductibles, and coinsurance.(13) Low-income people with Medicare who are also eligible for Medicaid receive coverage for Medicare's cost-sharing requirements and services that are not covered by Medicare such as prescription drugs and some long-term care.(14) As part of the 1988 Medicare Catastrophic Coverage Act, a federal assistance program was created to help low-income people with Medicare who do not qualify for Medicaid to pay for some of Medicare's cost-sharing requirements. Congress enacted an entitlement program, Qualified Medicare Beneficiary (QMB), for people with incomes at or below 100 percent of the federal poverty level and with limited assets. QMB pays for Medicare premiums, and deductibles and coinsurance if enrollees see Medicaid-certified doctors. QMB is implemented through each state's Medicaid program, and both states and the federal government fund QMB. The states administer the program, and federal agencies provide oversight. In 1990, Congress expanded the low-income assistance program by adding a new program called Specified Low-Income Medicare Beneficiary (SLMB) that requires that states provide Medicaid payments to cover an eligible individual's Medicare Part B premium. The program, which was implemented in 1993, was originally intended for people with incomes between 100 percent and 110 percent of the federal poverty level, but the eligibility requirement changed in 1995 to include those up to 120 percent of the poverty level. (See chart on page 11 for actual income amounts.) In 1998, two block grant programs called Qualifying Individual 1 and 2 (QI-1, QI-2) were added for those between 120 percent-135 percent of the Federal poverty level, and those between 135 percent-175 percent, respectively. Enrollees in QI-1, like SLMB, get their Medicare Part B premium covered each month, while those qualifying for QI-2 get a small portion of their Medicare Part B premium covered (\$3.09 a month).(15) Collectively QMB, SLMB, QI-1 and QI-2 are called the Medicare Savings Programs (Savings Programs).

The administration and oversight costs for all four of the Savings Programs in New York are split between the federal government (50 percent), the state (25 percent), and the county (25 percent). Each state's Medicaid agency pays for QMB and SLMB benefits for which the federal government partially reimburses the agency. States pay between 50 percent-83 percent of the cost of the benefits depending on the state's federal reimbursement formula. In New York State, the federal government pays for 50 percent of the cost of the benefits, with the remaining 50 percent covered by 25 percent paid by the State and 25 percent paid by the county. The federal government funds the full cost of the benefits for QI-1 and QI-2, both federal block grants to the states.

Medicare Savings Programs occupy an unusual place on the Medicare-Medicaid continuum. While those enrolled in the Savings Programs do not receive full Medicaid benefits, they are required to go through an application process similar to those applying for full Medicaid.(16) In New York, people applying for QMB must fill out a Medicaid application and receive a Medicaid card to get their coinsurance and deductibles covered. In contrast to the Medicare program, which people qualify for by age or disability, eligibility for the Savings Programs is subject to means testing like any Medicaid program. In essence, the Savings Programs are examples of the "Medicaidization" of the Medicare program.

### Medicare Savings Programs 2001 Eligibility Standards

Medicare Savings Programs	Coverage	Income Limit-Individuals	Income Limit-Couples
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<b>QMB</b> Qualified Medicare Beneficiary	Pays for Medicare Part B premium, coinsurance, and deductibles	\$736	\$988
<b>SLMB</b> Specified Low-Income Medicare Beneficiary	Pays for Medicare Part B premium \$50 a month in 2001	\$879	\$1,181
<b>QI-1</b> Qualifying Individual-1	Pays for Medicare Part B premium \$50 a month in 2001	\$987	\$1,327
<b>QI-2</b> Qualifying Individual-2	Pays for a portion of the Medicare Part B premium \$3.09 a month in 2001	\$1,273	\$1,714

**Asset Limits** for all Programs: \$4000 (Single), \$6000 (Couple)

Assets include bank accounts, stocks, and bonds but not home, car, or burial fund of \$1500.

People who qualify for Medicare and either full or partial Medicaid benefits are called dual-eligibles. Because Medicaid covers the costs of Medicare premiums, coinsurance, and deductibles for people who qualify for QMB, and it covers either the entire or partial Medicare Part B premium for people with SLMB, QI-1 and QI-2, all people eligible for the Savings Programs are considered dual-eligibles.

### Applying for the Medicare Savings Programs in New York City

To fully understand the individual and systemic barriers affecting people who try to enroll in the Medicare Savings Programs in New York City, a working knowledge of how consumers apply for the programs and how state and federal agencies process the application is critical.

The process for applying for a Medicare Savings Program in New York City involves the following steps:

- 1. An individual goes to the local Medicaid branch office and gets an application for a Medicare Savings Program.** (17) If the applicant is applying for QMB, she must fill out the eight-page Medicaid application, and if she is applying for SLMB, QI-1 or QI-2, she fills out a one page, double-sided Medicare Savings Program application (also called a "Buy-In" application).
- 2. A Medicaid eligibility specialist meets with the applicant, pre-screens her for the Savings Programs, and sets up a follow-up appointment for the next week at the same local Medicaid office.**
- 3. At the follow-up appointment the Medicaid eligibility specialist conducts a face-to-face interview and reviews the applicant's documentation to determine if she is eligible.** This documentation includes bank statements, stock certificates, life insurance policies, Medicare card, proof of employment if any, proof of identity, and proof of residence.
- 4. Within 45 days of first applying, the applicant receives a Notice of Action from the local Medicaid branch office indicating if she is accepted for a Medicare Savings Program, pending Centers for Medicare and Medicaid Services (CMS) approval. If accepted, the applicant will be reimbursed back to the month in which she had her initial interview.** The applicant can request retroactive payments for the three months prior to the month in which she applied for SLMB and QI-1, but not for QMB. However, because QI-1 is a yearly federal block grant, those accepted into QI-1 can only be given retroactive payment back to the beginning of the calendar year. For example, for those who apply in February, retroactive payments can only go back to January.

Processing a Medicare Savings Program application in New York City involves the following steps:

- 1. The Medicaid eligibility specialist at the local branch office enters the applicant's information into a computer system to evaluate whether the person is eligible.** The computer system is the budgeting arm of the Welfare Management System (WMS). (The majority of

departments at the Human Resources Administration, New York City's human services agency, use WMS.) To be entered into the WMS system, each person who applies for a Savings Program is first screened for Medicaid eligibility. If a person is not eligible for Medicaid, she is screened for a Savings Program. The Medicaid eligibility specialist sends out a Notice of Action to the applicant (see above) stating whether she is eligible. Eligibility is conditional pending the federal government's approval of the application.

**2. The Medicaid eligibility specialist sends a paper form with the applicant's information to the Third Party Division of the Medicaid/MAP office.** There the information is entered into a database that is a sub-system of WMS. The Medicaid office can then determine whether an applicant has applied in other boroughs.

**3. New York State Department of Health electronically "sweeps" this sub-system on the 15th of every month.** The State checks whether the applicant has applied in any other city. Even though there is technically one WMS system, processing the Medicare Savings Programs' applications throughout New York State is carried out using two computer systems - one upstate and one downstate.

**4. The State electronically sends the Centers for Medicare and Medicaid Services (CMS) all of the applicants' eligibility information.** CMS checks the data against eight other databases and then sends a list of approved individuals to the State.

**5. Once a month CMS electronically informs the Social Security Administration (SSA) about who is eligible for the Medicare Savings Programs.** SSA needs to get this information by the 25th of the month in order to eliminate the charge for the Part B premium in an individual's check two months later. For example, if SSA gets the information by the 25th of August, the applicant sees the benefit in her October Social Security check.

While no legal timeframe exists for an application to move from the state level through the federal level, if the system works properly an applicant will get the benefit approximately five to six months after first applying.

### Poor enrollment in the Medicare Savings Programs

Under-enrollment in the Savings Programs has been a problem since the programs were implemented. An estimated 37 percent of those eligible for QMB and SLMB, or 2.5 million people, were not enrolled in 1999. (18) Only 3 percent of those eligible for QI-1 participate in the program. Because of under-enrollment, only 1 percent of the money made available by the federal block grant was spent in 1998, the first year that QI-1 was available.(19)

New York State has the fourth largest dual-eligible population in the country and the sixth largest number of people who are eligible but not enrolled in dual-eligible programs. (20) According to a study by Families USA, out of those New Yorkers who were eligible for QMB or SLMB in 1998, between 31 percent and 40.4 percent were not receiving the benefit, which represented a cost of between nearly \$78 million and \$101 million annually to people with Medicare in New York State.(21) In New York City, approximately 217,000 seniors are enrolled in the four Medicare Savings Programs, however there are an estimated 54,000 additional seniors who are eligible.(22)

Under-enrollment in New York State has significant consequences because people with Medicare in New York are more likely to need financial assistance to pay for their health care than in most parts of the country. New York State has a higher percentage of older adults living in poverty-18.4 percent-than in the United States as a whole-15.7 percent.(23) Among the Medicare population in New York City, there are a higher percentage of people with annual incomes below \$10,000 than in the U.S. as a whole.(24)

7. "President's Plan to Strengthen and Modernize Medicare for the 21st Century," Medicare for the 21st Century, White House, June 1999.

8. Cassidy, A. and Gold, M. "Medicare + Choice in 2000: Will Enrollees Spend More and Receive Less?" The Commonwealth Fund, July 2000.

9. Moon, M., Maxwell, S. and Segal, M. "Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries," The Commonwealth Fund, January 2001.

10. Nearly half of people with Medicare live below twice the poverty level (\$17,180 per person in 2001,) and 14% live

under 100% of poverty (\$8590 per person in 2001.) Henry J. Kaiser Family Foundation, "Medicare and Low-Income Beneficiaries: The Faces of Medicare," June 1999.

11. O'Brien, E., and Rowland, D., "Medicare and Medicaid for the Elderly and Disabled Poor," Kaiser Family Foundation: Kaiser Commission on Medicaid and the Uninsured, May 1999.
12. Henry J. Kaiser Family Foundation, "Medicare and Low-Income Beneficiaries: The Faces of Medicare," June 1999.
13. In 2001, Medicare Part A has a deductible of \$792 per benefit period, and Medicare Part B has a \$50 monthly premium and a \$100 deductible for the year. Most Part B health care services have a 20% coinsurance or copayment. The monthly Part B premium is projected to increase to \$106 in 2008. (Families USA, "Shortchanged: Billions Withheld from Medicare Beneficiaries.")
14. In 2001, the Medicaid income eligibility standard in New York is 87% of the federal poverty level (\$625 a month for an individual.).
15. The QI-2 benefit was designed to offset the increase in the Medicare Part B premium once Part B began to bear more of the overall program cost of home health care as a result of the Balanced Budget Act of 1997.
16. The Medicaid application gathers detailed information that is necessary to enroll those people who qualify for QMB and Medicaid, or SLMB and Medicaid ("QMB plus" and "SLMB plus" respectively.)
17. New York City Human Resources Administration sends caseworkers to the homes of eligible homebound people who want to apply for a Medicare Savings Program to assist them in filling out applications and collecting financial documentation.
18. Rupp, K., and Sears, J. "Eligibility for the Medicare Buy-in Programs, Based on a Survey of Income and Program Participation Simulation," Social Security Bulletin, 2000.
19. Nemore, P. "Variations in State Medicaid Buy-In Practices for Low-Income Beneficiaries: A 1999 Update," Kaiser Family Foundation, December 1999.
20. Families USA. "Shortchanged: Billions Withheld from Medicare Beneficiaries." Publication #98-103, July 1998.
21. Ibid. Efforts to get current numbers of eligible New York residents have been unsuccessful. Both CMS and New York State Department officials have claimed that State-specific data regarding potential enrollees is not very reliable.
22. New York City Federal Affairs Office Website, NYC Federal Program 2000.
23. Medicare State Profiles. Henry J. Kaiser Family Foundation, September 1999.
24. Thirty-four percent of seniors with Medicare in New York have incomes below \$10,000, in comparison to 30 percent of seniors in the U.S. These statistics were published in the 1990 U.S. Census reported in UHF Community Health Atlas 1994 and US Census Bureau, as cited in "Medicare Beneficiaries and HMOs: A Case Study of the New York City Market," Mathematica Policy Research, Inc., January 1998.

## Tracking Clients

After large numbers of calls to Medicare Rights Center's hotline (25) over many years, informing us about the problems facing dual-eligible New Yorkers as they try to enroll in the Medicare Savings Programs, we began an intensive year-long study to investigate, monitor, and document the experiences of New York City residents.(26)

### Phase 1

We initially screened callers from our New York State hotline to see if they were eligible for the Medicare Savings Programs. We were interested in learning whether older and disabled New Yorkers with Medicare throughout the state were familiar with the Savings Programs, prior to focusing on New York City residents. After narrowing our selection to include only those who met income and asset standards for the Medicare Savings Programs, we were left with a sample of 260 people. Those we found to be eligible had typically contacted us with concerns about paying for their health care and prescription drugs. Of the sample, 76 percent were women, 24 percent men, and 65 percent qualified for Medicare by age, and 35 percent by disability. Twenty-three percent (59 people) were from New York City and the rest were from other parts of the state. We surveyed all 260 individuals on the telephone and asked them about their awareness of the Savings Programs. Eighty-eight percent of those surveyed (228 people) were unfamiliar with them. While 109 (42 percent) people in our sample had visited Medicaid offices seeking financial assistance prior to our study, only 13 (12 percent) of them had been informed about the Savings Programs.(27) (See the section entitled "Applicants have received incorrect information about applying for the Savings Programs from Medicaid branch office staff," (pps. 22-25) which identifies why people visiting Medicaid offices might not become informed about all of the programs for which they are eligible.)

### Phase 2

Armed with the knowledge that most people eligible for the Medicare Savings Programs are unaware of their existence, we engaged in a year-long project in which we identified New York City callers who were eligible for the programs, educated them about the value of the programs, and informed them about how to apply.<sup>(28)</sup> We followed-up every three weeks with each client to learn whether they had visited their local Medicaid office to apply for a program, or to discover at what stage they were at in the process of either applying or getting benefits, and overall to the program they could save \$546 a year (in 2000) for their Medicare Part B premium to significantly more a year for their combined Part A and B premiums, coinsurance, and deductibles.<sup>(29)</sup> For those eligible for SLMB andQI-1, which would cover their Part B premium, we informed them that they would save \$546 a year (in 2000) and with these savings could cover two-thirds of the cost of the most basic Medigap supplemental insurance plan or other costs. After each initial call we sent the client written material that listed the income and asset requirements for each Savings Program and explained where to apply and what documentation was needed to apply.

In addition to tracking the individual and systemic barriers facing our callers as they tried to enroll in the Savings Programs, we hoped that our regular phone calls would encourage them to apply. Through our on-going contact with clients, we hoped to convey that Medicare Rights Center thought that enrolling in these programs was important enough to warrant a follow-up phone call every three weeks for many months.

We continued to track the 59 New York City callers from Phase 1 of our project, and augmented our sample with 45 other eligible New York City callers who contacted our hotline or who had been referred to us by our New York City community-based partners in the ensuing months. These were the results of our tracking system:

Of the 104 people we tracked over our year-long project:

- 33 people did not apply because they were: not interested in the programs; reluctant to go to the Medicaid office; ill; or confused about the programs.
- 31 people tried to enroll in the Savings Programs: 19 were unsuccessful; 7 received the benefit, 3 after waiting almost a year; 5 had just applied at the end of our study.
- 24 were lost to follow-up because of: clients no longer returning MRC's phone messages; disconnected phones; or referrals to other agencies based on language needs and homebound status.
- 14 were ineligible for the programs because of: high income or assets; or unsettled financial situations.
- 2 died during the course of the study.

25. With funding from the New York State Office for the Aging, Medicare Rights Center operates a New York State Health Insurance Counseling and Assistance Program (HICAP) hotline for New Yorkers with Medicare and their families and representatives, to answer questions about Medicare options, benefits, and rights.

26. As part of this study, Medicare Rights Center gathered insights from the Medicare Savings Task Force, a statewide group that develops strategies for increasing enrollment in the programs. Members include representatives of government agencies including the Social Security Administration, Centers for Medicare and Medicaid Services, Human Resources Administration/Medical Assistance Program, and the New York State Department of Health, and consumer service and legal groups like AARP, and the New York Lawyers for the Public Interest.

27. For more information on the Phase 1 findings see "Facts and Faces: Making Health Care Affordable for People with Low- Incomes," on MRC's Web site at [www.medicarerights.org](http://www.medicarerights.org).

28. Medicare Rights Center also received referrals from our network of New York City partners who are trained by Medicare Rights Center to serve as intermediaries for Medicare information and assistance to their own client base.

29. In 2000 the monthly Medicare Part B premium was \$45.50. In 2001 this figure rose to \$50 a month. Depending on their health care usage, people enrolling in QMB could get coverage for their Part A deductible of \$792 in 2001, Part B deductible of \$100 in 2001, and coinsurance payments for doctors' bills.

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## Barriers to Enrollment

As detailed above, Phase 1 of our project clearly indicated that people with Medicare are unaware that the Medicare Savings Programs exist. Our study however focuses on the barriers to getting enrolled in the programs once people with Medicare are familiar with them. In tracking our clients'

experiences in Phase 2, we identified five primary barriers:

- 1. Those eligible find the Savings Programs confusing and the application process arduous.**
- 2. People are reluctant to apply for the Savings Programs at a Medicaid office.**
- 3. Applicants have received incorrect information about applying for the Savings Programs from Medicaid branch office staff.**
- 4. Applications get lost and consumers have difficulty tracking an application as it moves through the processing system.**
- 5. Government officials at the city, state, and federal level give out inaccurate information about how the applications are processed, and how to determine if someone qualifies for the benefit.**

**1. Those eligible find the Savings Programs confusing and the application process arduous.**

The Savings Programs are confusing to people with Medicare because of their complicated titles and the way the programs are administered. First, the acronyms and full names of the Medicare Savings Programs, QMB- Qualified Medicare Beneficiary, SLMB-Specified Low-Income Medicare Beneficiary, and QI-1, 2 - Qualifying Individual, are complex and do not identify the purpose of each program. Thus educating people about the Savings Programs is difficult and consumers often cannot remember the name of the Saving Program for which they want to apply. Knowing the name of the specific program is important given that a different application form exists for QMB (the standard eight-page Medicaid application,) versus the one-page form used for SLMB, QI-1 and QI-2. The name change from Medicare Buy-In Programs to Medicare Savings Programs to describe the dual-eligible entitlements and block grants has also confused matters as Medicaid branch office staff and State Medicaid forms still refer to the programs as "Buy-Ins," while CMS is educating consumers to ask about the "Medicare Savings Programs." Better coordination regarding how the Savings Programs are marketed on local, state, and federal levels could prevent future confusion for eligible people with Medicare.

Secondly, people with Medicare do not understand the process of applying, which requires two visits to the Medicaid office, including a face-to-face interview. People with Medicare are used to the automatic nature of Medicare that does not typically require any visit to a government agency. People applying for the Savings Programs do not understand why they cannot send the application and copies of their financial documents to the Medicaid office, instead of going down to the office in person.

The following examples from MRC clients illustrate these barriers:

**Case Example:** Ms. B, an 80 year-old single woman, has an income of \$850 a month and savings under \$4000, making her eligible for the SLMB program. She received multiple calls from MRC before she agreed to apply for the SLMB program. To assist her in the process, MRC sent her an application to fill out at home, and informed her that she should take it with her to the Medicaid office. After Ms. B filled out the application, she sent it back to MRC instead of bringing it to the Medicaid office. She was unable to understand why a Medicaid office would have to process an application for a Medicare assistance program.

**Case example:** Mr. B is a disabled 50 year-old man with Medicare. His income and assets make him eligible for Q1-1. MRC started contacting Mr. B in July 2000 to educate him about applying for this Medicare Savings Program. Over the course of the next four months, MRC made a number of follow-up calls and re-sent material about QI-1 multiple times. Each time, Mr. B claimed that he was unfamiliar with a program called QI-1. He had asked friends about it, but no one had heard of this program or knew what QI-1 stood for.

**2. People are reluctant to apply for the Savings Programs at a Medicaid office.**

Many people who are eligible for Medicare Savings Programs do not apply because they are uncomfortable going to a Medicaid office. People with Medicare do not understand why they must apply for the Savings Programs at the Medicaid office if they are not applying for Medicaid. Additionally, those applying for QMB are also confused about the requirement that they get a Medicaid card and see Medicaid doctors to get coverage for their coinsurance.

People who view themselves solely as having Medicare, who are not eligible for Medicaid, mistrust a program that requires that they apply through the Medicaid system. Some clients describe having negative past experiences at Medicaid offices as the reason why they are reluctant to apply for the Savings Programs. Some of our clients claim that in past visits to Medicaid offices they have been treated with disrespect, and have been given both little information about how long they will have to wait before speaking with someone and limited assistance in filling out applications.

Medicaid offices are typically viewed as unpleasant offices to visit and the locations of some Medicaid offices deter potential applicants. Located in basements of buildings and other out-of-the-way places, they have unwelcome waiting rooms, traditionally long waits, and are usually understaffed. Medicaid offices visited by MRC staff included one that was situated in a hallway of a hospital, and another that was a windowless room in the basement of a building. One Medicaid office was located on a hill making it difficult for frail or disabled people to get to. (A more detailed description of our visits to local Medicaid offices is on pages 26-27).

The following examples from MRC clients illustrate these barriers:

**Case example:** Mrs. P is 73 years old and has a monthly income of \$712. She has very little savings, and is having problems paying for her health care. She was advised by an MRC counselor to apply for a Medicare Savings Program. Mrs. P states that she is a very proud woman and after working hard her whole life, she will not apply for a program through the Medicaid office.

**Case example:** Mrs. M is 77 years old and has a monthly income under \$700, which makes her eligible for the QMB program. She spends \$150 a month on medication and would benefit from the money saved by enrolling in QMB. She has refused to go down to her local Medicaid office because she went there in the past to inquire about other programs and had a bad experience.

**Case example:** Mr. P is disabled and has a monthly income of \$579. He has been to the Medicaid office in the past to apply for Medicaid. Mr. P states that in his visits to the Medicaid office in the past, Medicaid staff harassed him. They told him that he was not eligible for Medicaid and that there was "no reason for him to be in the [Medicaid] office." He refuses to go back to the Medicaid office "even if he has zero dollars to [his] name."

**Case example:** Mrs. N called MRC with questions about her health insurance options. She had not seen a doctor since her HMO terminated coverage at the end of 1999. Both Mrs. N and her husband have Medicare and a combined monthly income of \$1100 and assets under \$6000, which makes them eligible for the SLMB program. An MRC counselor suggested that they apply for a Medicare Savings Program to offset some of their out-of-pocket costs, but Mrs. N refused when she learned that she must go to a Medicaid office. "I've been down that road before." MRC was unable to convince Mrs. N to give the Medicaid office another chance and referred her to a clinic where she could get health care based on a sliding fee scale.

### **3. Applicants have received incorrect information about applying for the Medicare Savings Programs from Medicaid branch office staff.**

Medicaid branch office staff makes the assumption that any individual coming to the office is there to apply for Medicaid because it is the primary function of the Medicaid office. Even the typical intake sheets that clients must complete stating the reason for their visit to the Medicaid office do not list enrolling in the "Medicare Savings Programs," "Buy-Ins" or "QMB, SLMB, QI-1, QI-2," as an option. Not only is this confusing to an applicant, it also sends a message to Medicaid staff that the Human Resources Administration does not view enrolling people in Savings Programs as

central to its mission.

Though New York City Medicaid eligibility specialists have received two separate trainings about the Medicare Savings Programs in the last two years, no formal evaluations of their knowledge and understanding of the Savings Programs have been conducted. Because Medicaid provides the most comprehensive benefits of all of the dual-eligible programs, Medicaid eligibility specialists are trained to screen every client for Medicaid. But they do not always screen clients who are ineligible for Medicaid for other low-income assistance programs.<sup>(30)</sup> MRC's clients claim that some Medicaid eligibility specialists have no knowledge about the existence of the Savings Programs. Even when clients bring in written material about the programs, Medicaid branch office reception staff and eligibility specialists do not seem informed about the Savings Programs. We have heard from many applicants that they are told that they do not qualify for Medicaid even after informing the eligibility specialists that they are there to apply for SLMB or another one of the Savings Programs. Clients have informed us that they are put on a Medicaid Surplus Income program (Spend-down) that they don't wish to be enrolled in and can't afford, as it requires that they live off of the monthly allowable income standard for Medicaid (\$600 in 2000/\$625 in 2001.)<sup>(31)</sup>

Even when Medicaid branch office reception staff and eligibility specialists are familiar with the Savings Programs and know which application forms to provide to the client, applicants tell us that staff may be uninformed about the processing of the application and have given out incorrect information about the process and time frame for receiving the benefit. Medicaid eligibility specialists also do not seem to be completely knowledgeable about the coordination between the Savings Programs and other benefit or entitlement programs. Clients have had trouble getting accurate information about how enrolling in the Savings Programs can potentially render them ineligible for other entitlement programs in which they are enrolled like low-income housing or drug subsidies. For example, someone with a monthly income of \$660 who qualifies for a low-income housing entitlement based on his under \$700 monthly income, may jeopardize his housing once he enrolls in a Savings Program that pays for his Medicare Part B premium and brings his monthly income up to \$710. Because enrolling in the Savings Programs jeopardizes some entitlements but not others, consumers need accurate information about co-existing entitlements.

Our clients have stated that Medicaid eligibility specialists do not always collect the necessary documentation from them to prove their eligibility for one of the Savings Programs. Clients fear being denied for a program because an eligibility specialist only asked for copies of their Medicare cards and picture identification to submit with their application, without asking for any financial statements. Some Medicaid eligibility specialists may only have a limited understanding of the income and asset standards for the Savings Programs.

The following examples from MRC clients illustrate these barriers:

**Case example:** Ms. B has a monthly income of \$929 and applied for the QI-1 program at her local Medicaid office. She filled out the QI-1 application but when she was called into a Medicaid staff person's office, she was erroneously informed that her income was too high for the QI-1 program. (In 2000, the income limit for QI-1 for an individual was \$960.) Ms. B stated that she "was so disgusted and discouraged that I just threw [the application] away." When MRC called Ms. B to follow-up, she acknowledged that she has high prescription drug costs, cannot afford supplemental insurance, and is desperate for financial help. Ultimately Ms. B agreed to fill out another application but only with substantial encouragement from an MRC counselor.

**Case example:** Ms. N is a disabled 50 year-old Bronx resident with Medicare. She applied for a Savings Program in early August 2000. At her face-to-face interview she received very little information; Ms. N said that the interview took only five minutes and she was told only that "she would hear in the mail." The caseworker gave her no information about what program she might be eligible for or how long it would take to get a decision on her eligibility. When Ms. N asked about the possibility of retroactive payments, the eligibility specialist said that she didn't know

anything about retroactive payments and that Ms. N would "find out in the mail." At the end of August, Ms. N received her Notice of Action stating that she was eligible for QI-2. Ms. N was surprised because her calculations indicated that she should be eligible for QI-1. The Notice of Action recommended that Ms. N read the enclosed budget worksheet to understand how the decision was determined, but no budget worksheet was enclosed. Ms. N called the Medicaid office to get the worksheet sent, but the office refused, demanding that she come down to pick it up personally. Ms. N chose not to go back to the office.

**Case example:** Mrs. K, who recently turned 65, has a monthly income of \$667, which makes her eligible for QMB. She called the MRC hotline and was educated about the Medicare Savings Program. When she went to the Medicaid office in her area, she asked the receptionist for an application for QMB, and was told that she did not need an application for the program. The receptionist asked Mrs. K to sit down and told her that her name would be called. Two hours later Mrs. K was called into an office. The Medicaid eligibility specialist told her right away that she was not eligible for Medicaid. When Mrs. K informed the caseworker that she was there to apply for QMB, the caseworker gave her a form to fill out and asked her to wait again for her name to be called. Annoyed, Mrs. K left the office. She told MRC, "If you do not know what you need, [Medicaid staff] will not volunteer the information to you. Luckily I speak English and I know how to stick up for myself."

**Case example:** Mr. K is a 49 year-old man with Medicare who has AIDS. He has a monthly income of \$875. He went to his local Medicaid office to apply for the QI-1 program. When he returned for his follow-up interview he was informed that his enrollment in the Savings Program would make him ineligible for another benefit he was receiving called AHIP-AIDS Health Insurance Program. Based on this information, Mr. K decided not to pursue enrollment in a Savings Program. When he contacted MRC, a counselor corrected this inaccuracy, and advised him that enrolling in QI-1 would not jeopardize his AHIP status.

### **Medicare Rights Center's Visits to Medicaid Offices**

MRC staff has also conducted investigative visits to New York City Medicaid offices to engage first-hand in the process of applying for a Savings Program. The first visit was to a Manhattan Medicaid office, and the second was to a Staten Island office:

**Two members of the Medicare Rights Center staff went to a Manhattan-based Medicaid office posing as the children of a disabled mother with Medicare. The MRC staff people walked into the reception area and were asked why they were there. In response, MRC staff explained that the Human Resources Administration had sent them there to find out about low-income programs. They mentioned that their mother had an income of approximately \$670 and that they wanted to find out about low-income programs for people with Medicare, and asked specifically for "some program to pay for her Medicare Part B premium." The Medicaid staff person told them that no program like that existed, and that this office was only for applying for Medicaid. After the Medicaid staff person repeated that they could only apply for Medicaid at this office, she told them to put their names on a list titled Surplus Income. At that point the MRC staffers were told to go into the waiting room outside the reception area. Ten minutes later the same Medicaid worker came out into the waiting room and asked MRC staff why they were there, and upon hearing their response said quite angrily "This is a Medicaid office, unless you are here for Medicaid, you don't belong here." She told the MRC staffers that she knew of no program that would pay for someone's Medicare Part B premium.**

**The MRC staff asked if there was any written material to look at to show the Medicaid worker what program they were interested in. She handed them an envelope with information on how to apply for Medicaid and told them to read it before they left. At this time a woman sitting next to the MRC staffers told them that what they were interested in applying for were called "the buy-ins." She stated that she works for a health insurer and**

assists a lot of their clients in enrolling in the Medicare Savings Programs. She claimed that all the "Medicaid workers pretend they don't know about the programs and it's like this in every Medicaid office." She explained the programs in detail to the MRC staff people, who then went back into the reception area and asked about "the buy-ins." The Medicaid staff person handed them the one-page SLMB, QI application from a box with a big label which said "buy-ins." (They should also have received the QMB/Medicaid application since they had told the Medicaid staff person that their mother's income was \$670.) About 40 minutes later the MRC staffers' names were called and a different Medicaid worker brought them into a separate office. When he saw that the MRC staff members wanted to know about the Buy-Ins he informed them that they had put their names on the wrong list. He told them that they had to be pre-screened after filling out an application. When they inquired as to whether they could ask him a few questions about the Buy-In Programs, he said no and then directed them back to the initial waiting area and gave them an intake form with a number attached and told them to fill it out. The intake form was difficult to understand and had nothing on it about Medicare Savings Programs in its list of reasons for the visit to the Medicaid office. At this point, the MRC staff left the office.

Two members of the MRC staff accompanied an MRC client to a Medicaid office in Staten Island. The client was slightly disabled and walked with a cane. Because the office is located on top of a hill, the client was forced to take a taxi to the office instead of walking from the bus stop that was close by. MRC staff people accompanied the client into the Medicaid office and were told to write their names on a list. They mentioned that they were there to apply for a Buy-In Program. They were given a general intake form from the security guard at the reception area as well as the one page SLMB, QI-1, QI-2 application form. The intake sheet had no reference to the Medicare Savings Programs, Buy-Ins, QMB, SLMB, QI-1, or QI-2 as the reason for the visit. The MRC staffers helped the client fill out the application. Some of the questions were confusing and the client, who had been a doctor in the Philippines, had trouble understanding some parts of the application. By chance, while they waited they witnessed other individuals asking for applications for programs that would help them pay for Medicare costs. The security guards informed these individuals that the Medicaid office administered no program of that kind. The MRC staff assisted these other individuals by getting them "Buy-In" applications and explaining how the programs work. After waiting for two hours the MRC staffers and their client were called into a separate office. The eligibility specialist asked only to see the client's Medicare card and passport. She made photocopies and then told the client and MRC staffers to leave. The eligibility specialist did not set up a follow-up appointment for the client, nor did she look at any of the client's financial documents. MRC staff wanted to help the client get what she needed and did not want to create any hostility by challenging the Medicaid worker's actions. When MRC staff people asked the eligibility specialist about what would happen next, she said gruffly as she led them out of the office, "I don't know. She'll get some kind of notice if she's eligible in three to six months. I really don't know what happens next." Now, three months later the client has not yet received her Notice of Action and MRC staff is following up with her case.

#### **4. Applications get lost and consumers have difficulty tracking an application as it moves through the processing system.**

Applications are processed through multiple government agencies at the city, state, and federal level. Each agency either administers the applications or oversees the process in a vacuum with little understanding of the applications' prior or successive steps. For example, once an application moves beyond the city level, the city's computer cannot provide consumers or advocates with information about the status of the application.

There is no well-publicized, designated point person at each agency for consumers to contact to

learn if their application is lost, or to learn of the current status of their application. While consumer advocates have developed contacts at each government agency, access to information is still limited. It is not unusual for an MRC staff person to call a contact at one of the government agencies to learn about an application's whereabouts and to be told, "It hasn't made it to my desk yet, but that's all I can tell you."

At the time that the research for this report was conducted, there was only one individual entering applicants' data in the New York City Medicaid Third Party Division office. He was also the only person at that office who could give information about a client's status. When an MRC staff person contacted this office to learn about the status of an application, we were informed that any time that the Medicaid staff person spent talking to us meant time not spent entering applicants' information into the computer and potentially delaying their entrance into the Savings Programs' system.

No legal timeframe exists for an application to move from the state level to the federal level, which compounds consumers' frustrations of not knowing an application's status. Following the initial Notice of Action received by the applicant within 45 days of applying for a Savings Program, a client receives no other information about the status of her case. While the process should take approximately five to six months from the date of application, many clients have experienced much longer waiting periods before getting the benefit. Others have waited close to a year only to find that their application was lost, or they were denied the benefit, sometimes incorrectly. Those who have been denied often cannot find out why. The following examples from MRC clients illustrate these barriers:

**Case example:** When Mr. G contacted MRC, he told MRC that he has very little money and goes to soup kitchens and senior centers for his meals and general assistance. Mr. G applied for a Medicare Savings Program in June 1998 and received a Notice of Action stating that he was eligible for the QMB program. After waiting nearly a year without receiving his QMB benefits, Mr. G called MRC for assistance. After making numerous phone calls to city, state, and federal offices, MRC staff discovered that Mr. G's application had never been transferred from the city to the state level. After the mistake was discovered, his QMB application was re-submitted. Mr. G finally received his benefits in December 1999, a year and a half after he first applied.

**Case example:** Ms. J, a 52 year-old disabled woman with Medicare, applied for the QMB program at a Brooklyn Medicaid office in July 1998. It was incorrectly processed as an application for the Medicaid spend-down program. She appealed the decision in a State Fair Hearing in January 1999 and was granted full QMB benefits retroactive to the date of her initial application. Six months later she was still waiting for her benefits. MRC intervened and found that there was miscommunication between the state and federal level resulting in the delay. MRC asked a staff member from the State Department of Health to fix the records. In March 2000, Ms. J started to receive the benefit.

**Case example:** Mr. and Mrs. G applied for a Medicare Savings Program in October 2000 and were informed by the Medicaid office that they were both eligible for the SLMB program. After waiting close to five months without receiving the SLMB benefit, they enlisted an MRC staff person to find out why. The MRC counselor contacted the Social Security Administration, who stated that the paperwork had not yet made it to the SSA's office, and SSA had no way to track the application. The same response came from CMS. After making additional calls to the Medicaid office at which the couple applied, and to the New York State Department of Health to whom the MRC counselor had to fax the clients' Notices of Action, she was finally able to track down the application and learned that the couple would receive their benefits in August, 10 months after they applied.

## **5. Government officials at the city, state and federal level give out inaccurate information about how the applications are processed, and how to determine if someone qualifies for the benefits.**

Over the course of our one-year study, MRC struggled to get accurate and current information

about the structure of the Medicare Savings Programs, as well as the protocol for administering these programs in New York City. In many instances, we were given conflicting and vague responses to our questions from local, state, and federal government agencies responsible for overseeing the programs. The complex nature of administering the Savings Programs demands that each government agency involved have experts that have a genuine and comprehensive understanding of how the programs work.

We received conflicting information in the following areas:

- Time frame for receiving a Notice of Action
- Income calculation to determine eligibility for the Savings Programs
- Medicaid cards for QMB enrollees
- Eligibility information in government publications

- **Time frame for receiving a Notice of Action**

The Notice of Action informs applicants that they have been accepted or rejected for a Medicare Savings Program pending CMS approval and must be sent to applicants within 45 days from the time of their application. (42 Code of Federal Regulations 435.911.) It is the only time constraint that exists throughout the entire application/enrollment process. On several occasions, we were given conflicting and incorrect information regarding this time limit. One staff worker at the New York City Medicaid Office of Program Integrity informed us that the time limit for receiving a Notice of Action was not 45 days, but four months.

One eligibility specialist at a local Medicaid branch office we visited informed us that our client would probably receive a Notice of Action within three to six months, but that there was no specific time limit. This was a surprising response given that Medicaid eligibility specialists are responsible for sending out the Notice of Action.

- **Income calculation to determine eligibility for the Savings Programs**

We were given incorrect information by a government agency about how to calculate applicants' incomes to determine their eligibility for the Savings Programs. People with Medicare automatically have \$50 removed monthly from their Social Security checks to pay for their Medicare Part B premium. When applicants are asked about their income, they naturally give the income figure that appears on their Social Security check, which is their income minus \$50 that has already been removed. New York City's Medicaid Office of Program Integrity erroneously informed MRC for many months that the Medicare premiums should not be counted as income in determining eligibility for the Medicare Savings Programs. We had been advised similarly on this point by a social service agency specializing in benefits management and felt confident in this information. As a result, MRC initially screened its clients for the Savings Programs using incorrectly calculated income levels. After months of using incorrect information, we learned from the New York State Department of Health that the monthly Medicare Part B premiums do count as income (89 ADM-7 p.7). We question how many people in New York City have been incorrectly screened for the Savings Programs by local Medicaid offices and social service agencies in the past.

- **Medicaid cards for QMB enrollees**

An MRC client, who was enrolled in QMB, was informed by her doctor that she needed a Medicaid card so that he could bill Medicaid for her coinsurance costs. MRC asked the New York City Medicaid Office of Program Integrity if people in the QMB program received Medicaid cards and was informed that QMB recipients do not receive Medicaid cards, but rather Medicare knows to forward the bill for the coinsurance to Medicaid after it has paid its portion of the claim. Not satisfied with this answer, we contacted the New York State Department of Health and learned that in order for Medicaid to pay for Medicare coinsurance and deductibles, a person must have a valid Medicaid card and number. Once notified of this requirement, we advised the Medicaid Office of Program Integrity of this condition. Medicaid made the requisite changes to the database, and we were able to obtain a Medicaid card for our client. We were also able to ensure that our future clients with QMB

would know that they needed a Medicaid card to get full QMB benefits. We question how many people who have enrolled in QMB in New York City were denied health care services over the last decade because they were not provided with QMB Medicaid cards.

- **Eligibility information in government publications**

MRC also found examples of incorrect information disseminated through government publications. The description of the QMB program on the Centers for Medicare and Medicaid Services' Web site was misleading. It states that "Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers." The New York City Medicaid Office of Program Integrity had informed MRC staff that in order for coinsurance for Medicare services to be covered under the QMB program, a QMB enrollee must see doctors that participate in both Medicare and Medicaid, not just Medicare. When we contacted the New York State Department of Health, staff confirmed that in order for people with QMB to get their Medicare coinsurance amounts paid for, they must see doctors that are both Medicare- and Medicaid- certified.

- **Key Questions Remain**

At the end of the study, MRC was not able to determine the answers to a number of key questions regarding the Medicare Savings Programs:

1. MRC did not know how to advise our clients about how to track their own application once it has been entered into the Medicaid agency's database to learn if they have been accepted into the program, when they will begin to receive their benefit if accepted, or why the benefit has been delayed.<sup>(32)</sup>
2. We were not able to ascertain where HRA or other government agencies maintain Savings Programs' applicants' physical files or for how long they keep them.
3. We continue to receive conflicting information as to whether an applicant must bring original documents to the Medicaid office when they apply for the Savings Programs or if copies will suffice.

## Research

Over the course of our project, MRC staff interviewed a number of authorities on the Medicare Savings Programs and read journal articles and studies about the successes and failures of the Savings Programs throughout the country. For our interviews, the subjects included representatives of the New York City Medicaid Office of Program Integrity, Centers for Medicare and Medicaid Services Region II staff, New York State Department of Health Office of Medicaid Management, Social Security Administration Program Operations Office, and social service agencies in New York City who assist clients in applying for the Medicare Savings Programs. We also interviewed Patricia Nemore,<sup>(33)</sup> who has written extensively on the variations in how the Savings Programs are administered throughout the country, and spoke to state insurance regulators throughout the country about their concerns relating to under-enrollment. When speaking to government officials, the interviews consisted of asking each individual to explain either the administration of certain aspects of the Medicare Savings Programs' application and enrollment process or their experiences working with the programs. We also asked each individual to identify any barriers they saw to increased enrollment. Those interviewed agreed that the government could do a better job to publicize the Savings Programs, but that eligible people with Medicare don't view themselves as recipients of a Medicaid program and are reluctant to apply for a Medicare program through a Medicaid office. They acknowledged that Medicaid office staff are geared to get people enrolled in Medicaid, and as the offices were understaffed and suffered high attrition rates, it was unrealistic to expect that they could administer the Savings Programs. They agreed that bureaucracy slowed down the process of getting the benefits to those eligible for them.

30. All clients are supposed to be screened for all low-income assistance programs. An administrative directive to this effect, "Medicare Premium Payment Program 00 OMM/ADM-7," was issued by the New York State Department of Health on September 1, 2000 to all Medicaid offices throughout New York State.

31. Spend-down is a program that allows people to qualify for Medicaid even if their income or assets exceed the

Medicaid eligibility requirements. Generally, a person qualifies for Medicaid each month that his medical expenses equal or exceed his spend-down amount.

32. John Brunelle of the New York State Department of Health and Richard Finkelstein of New York City HRA/Medicaid informed us that they accept phone calls from consumers about the Savings Programs, however their phone numbers are not well publicized.

33. Nemore authored "Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries: A 1999 Update." The Henry J. Kaiser Family Foundation, December 1999.

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## Conclusions and Policy Recommendations

MRC staff members who worked with clients and spoke to Medicaid eligibility specialists and government staff encountered a myriad of systemic failings with the Medicare Savings Programs in New York City. The burden of applying combined with incorrect information and inadequate assistance, processing failures, and poor administration undermine the viability of these programs. They frustrate eligible individuals and impede their ability to benefit from these programs. It is no wonder that many people eligible for the Medicare Savings Programs are not getting the benefits to which they are entitled.

The success of entitlement programs like QMB and SLMB, and block grants like QI-1 and QI-2, depends on whether those who meet the eligibility criteria are enrolled. Under-enrollment poses a special risk for the block grant programs QI-1 and QI-2 which will be re-evaluated in 2002.(34)

Recommendations to increase enrollment in the Savings Programs fall into two categories: improved outreach and education, and improved administration of the Savings Programs. Because this report focuses on the latter, the following recommendations address ways to improve the administration of the Medicare Savings Programs.

### Federal-level Reforms

- *Administer the Medicare Savings Programs through the Social Security Administration (SSA).*

The multiple government agencies that currently administer the Savings Programs create an inefficient structure. Each agency has a compartmentalized function that limits its accountability for the entire administrative process, and limits its knowledge about how the Savings Programs work. If the Savings Programs were federal programs and SSA took over their administration, much of the confusion between government agencies could be eliminated. SSA is a logical place to centralize these programs as the agency already enrolls people in Medicare and has the responsibility for administering the Supplemental Security Income program (SSI). Given that QMB, SLMB, QI-1 and QI-2 are Medicare assistance programs that pay in full or in part for Medicare Part B premiums, they should be administered through the agency responsible for assuring that Medicare Part B premiums are paid each month. Presently in New York State, the Social Security Administration is required to automatically enroll everyone with SSI into a Medicare Savings Program that pays for his or her Part B premiums. SSA's role could be expanded to screen all people with Medicare for the Savings Programs. If SSA administered the entire program, it could better track all applications.

The Savings Programs were created for people with Medicare who do not qualify for Medicaid. Having Medicaid administer a Medicare program is a poor use of Medicaid's resources and further burdens an already overtaxed agency. Removing Medicaid's role would eliminate the welfare stigma barrier cited frequently by our clients and by policymakers, and acknowledged by government officials. Allowing individuals to enroll in the Savings Programs at local Social Security offices would be a welcome alternative to the current scenario.

From a health service delivery perspective, federalizing the programs would eliminate the need for people enrolled in QMB to see Medicaid-certified doctors. People receiving the QMB

benefit would have the same choice of doctors as everyone else with Medicare.

To ensure that federalizing the Savings Programs would be successful, Congress would have to appropriate sufficient funds to SSA to cover the costs of the benefit and of administrating the program. However, Congress already gives SSA \$1 billion annually from the Medicare Part A Trust Fund for Medicare-related activities.<sup>(35)</sup> Congress should investigate whether some of these funds could be used to administer the Savings Programs.

- *Set national standards for administering the Savings Programs.*

Absent SSA running the Savings Programs, the Federal government should set national standards for the states to administer the Savings Programs. Any state agency that receives federal dollars should be held accountable to a set of standards, which should include reasonable time frames for each step of the enrollment process, and incorporate best practices used by states whose programs have been most successful at enrolling people with Medicare into the Savings Programs. Sanctions should be imposed upon those states that do not comply with national standards.

- *Develop and disseminate a Medicare Savings Program guidebook that explains the enrollment process for all government agencies that administer or oversee the Savings Programs.*

CMS and SSA should develop and disseminate a guidebook on the Medicare Savings Programs for all government agencies involved in administering or overseeing the programs. Each agency's staff should be required to understand not only their agency's role in the system but other agencies' functions as well. Consumer advocates could inform this educational process with their collected data about misinformation and the knowledge gaps that exist at different agencies.

### **New York State/City-specific Reforms**

- *Create and publicize a toll-free hotline for consumers to ask questions about applying for the Savings Programs, and to track the status of their application.*

A state-specific toll-free phone number should be created so people enrolling in the Savings Programs can call in, enter their Social Security number and speak with an individual about how to apply or to learn the status of their application.<sup>(36)</sup> Currently there is no centralized hotline to provide consumers with this information. Individuals at each government agency involved in the process should be designated to speak to Savings Program applicants to answer questions regarding the time frame for the benefit or steps in the process.

- *Develop a computer system for the Medicare Savings Programs for the entire state with direct data entry capabilities for Medicaid eligibility specialists in branch offices.*

Rather than the current bifurcated system, New York State should rely on one computer system to insure that all Medicare Savings Program information is in one place. One system would coordinate the program and would minimize errors. More resources should be allocated to hire staff that can enter applicants' data. Rather than relying on the paper application system, each local Medicaid office should have a Savings Program computer terminal where staff can enter data about Savings Program applicants, screen them for eligibility and determine if they have applied in other boroughs. The computer system could trigger the production of Notice of Actions, and send the applicants' information automatically to the State level.

- *Raise or abolish asset limits.*

New York State should raise or abolish asset limits because using a more generous

standard would insure greater participation in the Savings Programs.<sup>37</sup> Removing the asset limit would simplify the application process; the Medicaid office would no longer need to collect and certify information about a person's resources and could reduce the need for a face-to-face interview. (See next recommendation). Nationally, approximately a quarter to a third of states use more generous standards to determine eligibility than other states, allowing a greater number of people to be eligible. Alabama has eliminated the asset test altogether. <sup>38</sup> Another option would be to increase the amount allowed for a burial fund (currently \$1500) so an individual could have greater assets and still be eligible.

- *Eliminate the face-to-face interview requirement for all counties in New York State.*

New York State should allow people to mail in applications for the Savings Program applications along with copies of their financial documents for certification. Nineteen states use mail or phone applications in all or limited circumstances, without a face to face interview.<sup>39</sup> Currently re-certification for QI-1 and QI-2 in New York City already occurs through a mail-in system. Extending this system to the initial application for all of the Savings Programs would make it easier for homebound individuals and those unable to go to a Medicaid office to apply for the programs. Short of eliminating the face-to-face interview, New York City should end the requirement of two visits to a Medicaid office. If an applicant forgets to bring his financial documentation when he visits the Medicaid office, he should be able to mail in copies of his financial papers after his interview.

- *Create a simpler application form for enrollment in the QMB program.*

New York's QMB application is an eight-page application that is used by individuals to apply for Medicaid, while the SLMB, QI-1, and QI-2 application is only one-page. Yet the only requirements necessary to qualify for QMB are to meet income and asset standards similar to SLMB, QI-1 and QI-2. Given that QMB enrollees are not applying for all of the benefits associated with Medicaid, requiring them to fill out a complex Medicaid application is burdensome and unnecessary.

The Medicare, Medicaid and SCHIP Benefits and Improvement Act of 2000 (Public Law 106-554), implemented in December 2000, required that the Secretary of the Department of Health and Human Services develop and distribute to states a nationally uniform QMB/SLMB application form. Creating a uniform application for QMB/SLMB enrollment is a positive step as long as the intention is to simplify what is required to apply for QMB and not expand what is required to apply for SLMB. But states will not be mandated to use this new application. They will have the option to use their own forms, and this uniform application may be rarely used. We recommend that the uniform application be a simple short form that is easy to understand and that its use be mandated.

- *Change Medicaid Intake forms to include Medicare Savings Programs as a "reason for visit" option.*

Local Medicaid branch offices ask everyone visiting the office to fill out an intake form to indicate why they are there. The State should require that all Medicaid offices update their intake forms to include "Medicare Savings Programs/Buy-In Programs" as a potential reason for a person's visit. By not including this option, the Medicaid office is perpetuating the view that taking applications for the Savings Programs is not central to or even a part of the Medicaid agency's mission. It also confuses people with Medicare who are already unsure about being at a Medicaid office to apply for what they consider to be a Medicare assistance program. Local Medicaid offices should also prominently display posters with information about the Savings Programs, including details about eligibility requirements and what benefits the Savings Programs offer.

- *Set standards for training of Medicaid branch office staff.*

The State should develop educational training programs for Medicaid branch office staff

about the Medicare Savings Programs, how the administrative process works and what information Medicaid staff should provide to people with Medicare applying for the Savings Programs. Our clients repeatedly reported that the Medicaid staff offered them little to no information about how long it would take to get the benefit, or what was to happen after the application left the Medicaid branch office. Trainings should be offered on a frequent basis to account for the high attrition rate of Medicaid branch office staff and should be evaluated for their effectiveness.

34. Implemented in January 1998 as a five-year block grant program, QI-1 will need to be reauthorized in 2002 for the benefit to be extended. Legislators may want to consider the value of renewing a block grant like QI-2, because an application costs the county and state \$100 to process, for a benefit to the consumer of \$37 a year.

35. Richard Chambers, Acting Deputy Director, Center for Beneficiary Services, CMS, Advisory Panel on Medicare Education meeting, April 26, 2001.

36. See footnote 32.

37. A new study by the Public Policy and Education Fund of New York entitled "Your Savings or Your Health: How Asset Limitations Harm Low-Income People," (May 2001) finds that the presence of an asset test prevents eligible individuals from applying for Medicaid because of the invasive application procedure.

38. Nemore, P. "Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries: A 1999 Update," The Henry J. Kaiser Family Foundation, December 1999.

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