Streamlining Medicare and QMB Enrollment for New Yorkers:

Medicare Part A Buy-In Analysis and Policy Recommendations

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Executive Summary

Numerous older adults and people with disabilities are eligible for Medicare Parts A (hospital care) and B (physician services) but cannot afford their premiums and other costs because of limited income. In particular, older adults who qualify to enroll in Medicare but who lack ample work history with the Social Security Administration (SSA) must pay hefty monthly premiums to enroll in Medicare Part A (up to $450 per month in 2011). In 2005, 1.6 million older adults (5 percent) in the United States and 189,000 older New Yorkers (8 percent) failed to qualify for premium-free Part A. Persons with no or limited Social Security work credits include individuals who work outside of the Social Security payroll tax system, people who hold jobs as domestics, for example, or as restaurant, seasonal or construction workers, as well as recent immigrants for whom English is not their first language. Because these individuals often hold low-wage jobs and do not qualify for Social Security retirement benefits, they often have incomes too limited to afford to enroll in Medicare.

The Medicare Savings Programs (MSPs) are state Medicaid assistance programs designed to secure Medicare participation for eligible low-income persons by paying their considerable Medicare expenses. Persons must apply for the MSPs through their state Medicaid agencies or local Medicaid offices. In New York, Local Departments of Social Services (LDSS) offices and New York City Human Resources Administration (HRA) offices determine eligibility for the MSPs, with oversight by the Department of Health (DOH).

The most generous MSP, the Qualified Medicare Beneficiary (QMB) program, pays for consumers' Medicare Part A and B cost-sharing and premiums, including the Part A premium when owed. QMB serves Medicare beneficiaries with incomes up to 100 percent of the federal poverty level and limited resources, but states can use more liberal financial eligibility criteria and take other steps to ease the application process. While QMB extends to persons who do not qualify for full Medicaid coverage, most QMB enrollees also have full Medicaid coverage.

For those with too few Social Security work credits for premium-free Part A, payment of the Part A premium through QMB (known as the Part A buy-in benefit) makes it possible for them to enroll in Medicare and helps reduce medical and prescription drug expenditures. Having Medicare improves access to care, since most providers accept Medicare patients. Additionally,

enrollment in QMB helps persons obtain and pay for their prescription drugs, since all MSP enrollees automatically receive Medicare Part D drug coverage and Extra Help, the federal subsidy that pays the Part D premiums, deductibles and copays. Finally, since Medicare pays primary to Medicaid and state pharmaceutical assistance coverage, Part A buy-in conserves state funds considerably by shifting state costs paid for the Medicaid program and New York's pharmaceutical assistance program (Elderly Pharmaceutical Insurance Coverage [EPIC] program) to Medicare, which the federal government finances in full.

Despite its value for eligible individuals, numerous barriers still prevent most people who qualify from enrolling in the Part A buy-in benefit. In addition to a general lack of awareness about the Part A buy-in program, substantial structural barriers impede access to the program even among those who know about it and advocate for themselves or others to be included in it. First, QMB requirements create a "catch-22" for low-income older adults without premium-free Part A: they cannot afford to enroll in Medicare until they have QMB, but they need Medicare in order to qualify for QMB. Second, Part A buy-in, the payment of Medicare Part A premiums through QMB, requires application, eligibility determination and enrollment in two distinct programs: Medicare, administered by the federal government, and QMB, administered by state and local governments. As a result, persons must often undergo two separate application processes through two separate agencies to receive Part A buy-in. Third, Medicare enrollment restrictions and penalties for those who do not enroll in Medicare when they first qualify impede the ability of persons to enroll, and cause gaps in coverage.

This paper describes the administration of the Part A buy-in program in New York and the effect of state efforts to improve participation. In particular, three key measures have enabled New York to automate Part A buy-in enrollment for individuals in New York with Supplemental Security Income (SSI), a program for people with limited income and resources who are 65 or older, blind or disabled, so that an application for SSI also serves as an application for Medicaid, QMB and Medicare Parts A and B: (1) New York is an "auto-accrete state" which means that an application for Supplemental Security Income (SSI) through SSA also serves as a Medicare Part B application and automatically triggers Part B consideration and enrollment by SSA; (2) New York is a Part A buy-in state so it can enroll Medicaid recipients with Part B in Part A buy-in (regardless of enrollment period), without the need for the individual to first apply for Part A

through SSA; (3) New York has instituted proactive measures to consider all SSI individuals with Part B for Part A buy-in, and to enroll them in Part A buy-in without requiring that they first submit a separate application for QMB. Streamlining and automating Part A buy-in for SSI recipients has vastly improved participation in the program and, according to New York's estimates, saves money for state and local governments. In 2004, New York Medicaid projected annual net local and state savings of $75 million as a result of its Part A buy-in reforms. In July 2004, the month all three of these measures first coexisted in New York, Part A buy-in enrollment jumped to 92, 926, a 7300 percent increase from the prior month.

New York's Part A buy-in measures have made less headway in helping the thousands of eligible persons without SSI who remain unenrolled. Problems persist despite otherwise positive reforms New York has made to ease barriers to QMB participation. In 2008, New York eliminated the face-to-face interview requirement and the resource test for the MSPs. While these reforms have notably simplified the QMB application process in New York, persons without premium-free Part A must still undergo an extremely arduous, multistep process to enroll in Part A buy-in. This paper includes case studies of the Part A buy-in enrollment process based on the experiences of consumers whom the Medicare Rights Center has intervened to assist. As demonstrated by the case studies, only a small minority of eligible individuals can be expected to complete this multistep application process, even with hands-on assistance, given: (1) the difficulty of this process; (2) the demographics of this vulnerable population and (3) the pervasive lack of awareness of the program among older adults, consumer service organizations and government agencies.

While reforms are needed to ease the Part A buy-in enrollment process for older New Yorkers without SSI, such measures alone will not suffice to streamline Part A buy-in enrollment processes. Enrollment in Part A buy-in hinges on successful information transfer between state and federal Medicaid data systems, but strict federal data-matching requirements can derail enrollment and cause delays. These problems affect persons without SSI but also threaten improvements made for the SSI population.

This report concludes with several recommendations to further improve the Part A buy-in process in New York and other states. First, it suggests that enrollment into Part A buy-in be simplified and automated as much as possible for those who are not eligible to receive SSI. The

two-agency enrollment process should be eliminated, and non-SSI recipients without Part A should automatically be screened for Part A buy-in no matter where they first apply, without having to go to another agency to complete additional paperwork. SSA already sends data to states as required by the Medicare Improvements for Patients and Providers Act (MIPPA), but states also need to share data with SSA if this "no-wrong-doors" policy is to succeed. Further, the time is right for such a reform, as automated enrollment processes and data exchanges are increasingly being encouraged by the federal government and others as a way to increase enrollment rates into a variety of public benefits. Second, onerous systems requirements applied to Part A buy-in data exchange between states and the federal government should be eased so that eligible consumers are reliably and seamlessly enrolled in Part A buy-in without delay. Third, in order to prevent delays and misinformation related to Part A buy-in enrollment, front-line agency staff and advocates should be properly trained on the Part A buy-in process. As outlined in Medicare Rights case studies, low-income and limited English populations have the greatest difficulty accessing needed benefits and are often erroneously shifted from one agency to another, or their information is inaccurately entered into computer systems. Agencies and advocates that work with these vulnerable individuals should receive extensive training about the Part A buy-in process to promote effective outreach and screening to increase enrollment rates. Government agencies should also work with them to conduct targeted outreach to potentially eligible individuals since this approach has proven to be effective. Finally, Part A buy-in participation rates will rise significantly if other states institute measures New York has used to boost Part A buy-in enrollment and use New York's experiences to identify additional opportunities for reform. For example, the above recommendations for reforming the Part A buy-in program for persons without SSI hold much promise for improving enrollment of non-SSI individuals in other states. These changes will gain the most traction if they are complemented by reforms to simplify the QMB application process, which have been successful in New York. In addition, states could significantly boost Part A buy-in enrollment for those with SSI by adopting all three key measures implemented by New York to automate enrollment for these individuals: (1) auto-accretion, also known as 1634 agreements; (2) Part A buy-in agreements; (3) consideration of all SSI individuals with Part B for Part A buy-in and enrolling them without requiring a separate application for QMB first.

CMS guidance to states regarding minimum standards and best practices could also prompt states to adopt new policies to promote Part A buy-in participation. The need for reform is particularly important in light of new CMS initiatives to coordinate care and health care financing for persons with both Medicare and Medicaid. These delivery system reforms will be undermined unless low-income older adults who qualify can obtain Medicare and MSPs to help pay their expenses. Finally, as states revamp and streamline enrollment systems under health reform, they risk marginalizing this population unless they also retool the systems that serve them.

Introduction

Medicare provides crucial health coverage to 47 million older adults and younger persons with disabilities, but requires beneficiaries to share in the cost of their care. All Medicare beneficiaries must pay deductibles and coinsurance for Part A (hospital care) and Part B (physician services) and a monthly Part B premium (up to $115.50 in 2011 for those without high incomes).[1] Most Medicare beneficiaries do not have to pay a premium for Part A. They receive a full federal subsidy for the Part A premium (premium-free Part A) if they (or a spouse) have paid Medicare payroll taxes and earned Social Security work credits for 10 years.[2]

However, those without the requisite work credits to qualify for premium-free Part A must agree to pay a monthly premium (up to $450 per month in 2011) to enroll in Part A. In 2005, 1.6 million older adults (5 percent) in the United States failed to qualify for the full federal Part A subsidy. In New York State alone that year, 189,000 older New Yorkers (8 percent) lacked premium-free Part A.[3] Persons age 65 or over can enroll in Part A with a premium (premium-Part A) if they currently reside in the United States and are either: (1) a U.S. citizen or (2) a permanent U.S. resident (green card holder) who has lived in the U.S. continuously for five years prior to application.[4] Many of those who must enroll in premium-Part A include people who work outside of the Social Security payroll tax system, people who hold jobs such as domestic, restaurant, seasonal or construction workers, as well as recent immigrants for whom English is not their first language.[5] Because these individuals often hold low-wage jobs and do not qualify for Social Security retirement benefits, they often have incomes too limited to afford the premiums required to enroll in Medicare Part A and pay Medicare expenses.

Fortunately, state Medicaid assistance programs help low-income older persons to afford to enroll in Medicare and pay its costs. The poorest older adults qualify for full Medicaid, which provides wrap-around coverage to Medicare. Full Medicaid covers additional services that Medicare excludes, such as extensive long-term care, as well as Part B premiums and cost-sharing amounts.[6] Full Medicaid does not cover Part A premiums or cost-sharing, however.

First enacted in 1988, the Medicare Savings Programs (MSPs) were intended to extend Medicare cost-sharing assistance to those persons who may not otherwise qualify for full Medicaid benefits. As a form of Medicaid coverage, MSPs are administered by state Medicaid agencies

with federal oversight from the Centers for Medicare & Medicaid Services (CMS). If a state chooses to participate in the Medicaid program, it must offer MSPs. To enroll in them, persons must apply for benefits through their state Medicaid agencies or local Medicaid offices and prove that they meet eligibility requirements. In New York, New York county Department of Social Services (LDSS) offices and New York City Human Resources Administration (HRA) offices determine eligibility for the MSPs, with oversight by the Department of Health (DOH).

The Qualified Medicare Beneficiary (QMB) program, the most generous MSP, is available to persons with incomes up to 100 percent of the federal poverty level (FPL) and limited resources,[7] but states can use more liberal financial eligibility criteria.[8] In 2008, New York eliminated the resource (also known as asset) tests for all MSPs, including QMB.[9] Eight other states (including the District of Columbia) do not apply a resource test to the MSP.[10] While QMB extends to persons who do not qualify for full Medicaid coverage, most QMB enrollees also have full Medicaid coverage. For example, in 2008, an average of 17,414 New Yorkers had QMB without full Medicaid as opposed to an average of 333,455 individuals who had QMB with full Medicaid coverage.[11]

QMB provides access to health care for its recipients by covering all Medicare Part A and Part B coinsurances and deductibles, Part B premiums, as well as Part A premiums for those who must pay them. QMB enrollees can receive care from any Medicare provider without having to pay Medicare deductibles or coinsurance.[12] Thus, QMB enrollees have better access to, and make better use of, medical services than people who qualify for the MSP but do not enroll.[13] Additionally, QMB and all of the MSPs help low-income persons pay for their prescription drugs. MSP enrollees automatically receive Medicare Part D drug coverage and Extra Help, the federal subsidy that pays Part D's premiums, deductibles and copays.[14]

For those low-income individuals who fail to qualify for premium-free Part A, payment of the Part A premium through QMB (known as the Part A buy-in benefit) is especially valuable. For uninsured or underinsured older New Yorkers, the Part A buy-in benefit's payment of Medicare Part A premiums and costs makes it affordable for them to enroll in Part A and get hospital and other care. Similarly, by ensuring Part A coverage, Part A buy-in expands access to hospital services for those individuals who also qualify for full Medicaid coverage, because QMB pays

Part A premiums while full Medicaid cannot. For persons with Medicaid, having Medicare Part A expands access to care because most providers accept Medicare, as opposed to Medicaid.[15]

Increasing Part A buy-in enrollment also makes financial sense for states because it shifts the state's health care and prescription drug costs to the federal government. Since Medicare pays primary to Medicaid, boosting QMB enrollment reduces Medicaid spending and transfers health costs from Medicaid, which is jointly financed by states and the federal government, to Medicare, which is fully funded by the federal government.[16] Additionally, in New York, increasing QMB enrollment among adults over 65 transfers costs for prescription drugs covered by the state pharmaceutical assistance program (Elderly Pharmaceutical Insurance Coverage program [EPIC]) to the federal government, since QMB individuals automatically receive Extra Help and Part D, which together cover the vast majority of participating individuals' drug costs.[17]

However, notwithstanding the benefits provided by QMB for persons without premium-free Part A and others, most eligible persons do not participate in the program. Nationally, only 33 percent of people who qualify for QMB are enrolled.[18] In recent years, states have taken several steps to ease barriers to QMB participation.[19] In 2008, New York eliminated the face-to-face interview requirement and began allowing mail-in applications, which has long been the practice in most other states.[20] That year, New York also removed the resource test for the MSPs.[21]

While these reforms in New York and other states have allowed more persons to qualify for benefits and have simplified the QMB application process, numerous enrollment barriers (which are the subject of this paper) hamper participation in the Part A buy-in benefit for more than one million eligible older adults across the nation.[22] In New York alone, thousands of eligible New Yorkers qualify for but do not receive the Part A buy-in benefit. The lack of access to QMB, coupled with prohibitive Medicare expenses, have created a pocket of uninsured or underinsured people over age 65. In 2005, New York had an average of 30,000 uninsured older adults and more recent estimates in 2008 indicate the number of uninsured older New Yorkers grew to 67,000.[23, 24] Additionally, in 2005, an additional 30,000 New Yorkers were enrolled in Medicare Part B but not Part A[25] and 33,000 New Yorkers over age 65 had Medicaid, but no Medicare coverage.[26] While further analysis (as detailed below) is needed to identify the percentage of individuals in these three cohorts who may qualify for Part A buy-in, anecdotal evidence

suggests that these cohorts include many New Yorkers who are eligible for, but not enrolled in, the Part A buy-in program.[27]

This paper examines the administration of the Part A buy-in benefit in New York and the effect of the state's reforms to improve participation. In recent years, New York has instituted important measures to break down barriers to Part A buy-in enrollment. In particular, in July 2004, New York expanded its capacity to enroll persons in the benefit by entering into a "Part A buy-in agreement" with CMS.[28] New York's Part A buy-in agreement, together with other measures, have automated and vastly improved Part A buy-in enrollment for those who receive cash assistance through Supplemental Security Income (SSI), a program for people with limited income and resources who are 65 or older, blind or disabled. While we acknowledge New York's notable success in helping persons with SSI access Part A buy-in, the impact of New York's buy-in reforms fall short in two critical ways. Most importantly, New York's Part A buy-in policies have failed to simplify enrollment for those older New Yorkers who do not qualify for SSI, most of whom still have an arduous two-step application process to obtain Part A buy-in. In addition, New York's buy-in reforms rely on antiquated data systems. System problems threaten to undermine the effectiveness of Part A buy-in program reforms for all older New Yorkers who qualify for the Part A buy-in benefit. We conclude with proposed reforms to resolve these long-standing problems in New York and with lessons learned. CMS guidance to states is needed to help them take these important steps. The need for these reforms takes on heightened importance given new initiatives by CMS to coordinate care for persons with both Medicare and Medicaid and to adjust financing of their health care. Essential to efforts to coordinate care for low-income older adults is to ensure their participation in all health coverage for which they qualify.

Background

Barriers to Participation in Part A Buy-In

While a general lack of awareness about the Part A buy-in program is a considerable factor in its consistently low participation rate, substantial structural barriers impede access to the program, even among those who know about it and advocate for themselves or others to be included in it. First, nonfinancial eligibility rules for QMB can create an impossible hurdle for many people with low incomes to overcome. In order to qualify for QMB, applicants must first be enrolled in

Medicare Part A.[29] To enroll in premium-Part A, applicants must have or be in the process of enrolling in Part B.[30] Accordingly, to qualify for QMB, which is a program designed to assist people with low incomes pay Medicare costs that they cannot afford, applicants who do not qualify for premium-free Part A must first enroll in and pay premiums for both Medicare Parts A and B. As one advocate has noted, QMB requirements create a "catch-22" or paradox for these low-income older adults, because they need Medicare in order to qualify for QMB, but they cannot afford to enroll in Medicare until they have QMB.[31]

Second**,** even if an applicant could afford to secure and pay for Medicare prior to applying for QMB, the application process for Part A buy-in is too onerous for most applicants to complete. Part A buy-in, the payment of Medicare Part A premiums through QMB, requires application, eligibility determination and enrollment in two distinct programs: Medicare, which is administered by the federal government, and QMB, which is administered by state and local governments. Because SSA makes eligibility determinations for Medicare, and local Medicaid offices (LDSS or HRA) make eligibility determinations for QMB, applicants must complete applications through two different bureaucracies to receive the Part A buy-in benefit. As discussed more fully below, low-income assistance programs that require applications with two separate entities are extremely complicated and difficult for low-income older adults to navigate. These difficulties are magnified for immigrants for whom English is not their primary language.[32] The case example of Ms. D on page 26 illustrates these difficulties.

Third, Medicare enrollment restrictions and penalties for people who do not enroll in Medicare when they are first eligible complicate the two-step application process even further. Those who miss their Initial Enrollment Period for Medicare[33] can enroll in Medicare premium-Part A and Part B only during the first three months of each year (called the General Enrollment Period) and must then wait until July for their benefits to begin.[34] If they miss this three-month window at the beginning of the year to apply for Medicare, they could end up waiting as long as 15 months before their benefits start.[35] For example, if an individual tries to enroll in Medicare during April 2011, he or she will need to wait until the 2012 General Enrollment Period (January through March 2012) to apply for benefits, which will start in July 2012. Moreover, if persons enroll in premium-Part A outside of their Initial Enrollment Period, they often need to pay a late penalty surcharge. Persons who enroll in premium-Part A twelve months or more after they first qualify

must pay a ten percent premium penalty. The penalty lasts for twice the number of years that enrollment was delayed.[36]

Part A Buy-In Enrollment Procedures in New York

To help address the challenges posed by the "catch-22" application process of the Part A buy-in benefit and facilitate Part A buy-in participation, New York entered into a "Part A buy-in agreement" with CMS in July 2004.[37] Buy-in agreements allow states to elect to pay Medicare premiums for their Medicaid recipients who also qualify for Medicare.[38] Since the early days of Medicare, buy-in agreements have allowed states to opt to pay Part B premiums for SSI recipients and other Medicaid groups. Following QMB's enactment in 1988, CMS expanded Medicare buy-in agreements to permit states to also pay Part A premiums for those who qualify for QMB.

While all 50 states and the District of Columbia have Medicare Buy-in agreements with CMS to pay Part B premiums, 36 states, including New York, and the District of Columbia have Medicare buy-in agreements that include Part A premiums, as of December 2010.[39] Those states are known as "Part A buy-in states." The fourteen states that include Part B but not Part A in their buy-in agreements are called "group-payer states."[40]

Part A buy-in agreements help address barriers to Part A buy-in participation in three ways. First, Medicare buy-in agreements make it easier for QMB-eligible persons to enroll in Medicare by allowing them to enroll in Medicare at any time of the year, regardless of enrollment period (not just during the three-month General Enrollment Period) and by waiving premium penalties for late enrollment.[41] Second, Part A buy-in agreements help address QMB's paradoxical requirement that applicants have Medicare Part A before they enroll in QMB. In Part A buy-in states, states can approve persons for Part A buy-in and request that CMS add or "accrete" persons to CMS's master Part A buy-in file if they already have Part B. CMS then notifies SSA to enroll the applicant in Part A. Although the state's approval and accretion actions take place before the individuals' enrollment in Part A, CMS considers an individual's enrollment in Part A buy-in to be simultaneous with the Part A enrollment and thus, to satisfy the requirement that QMB participants first be enrolled in Part A.[42] Third, because Part A buy-in states can directly accrete persons with Part B to CMS's Part A buy-in file, Part A buy-in applicants already

enrolled in Part B need only apply for the benefit at their LDSS or HRA office and can skip the step of applying for Part A at SSA.[43]

In summary, Part A buy-in agreements remove many enrollment barriers caused by the structure of the Part A buy-in benefit. As described below, becoming a Part A buy-in state paved the way for New York to automate and substantially boost Part A buy-in enrollment for those who qualify for income support from Supplemental Security Income (SSI). In contrast, New York's Part A buy-in agreement has been much less effective in streamlining enrollment for those individuals who do not qualify for SSI. As a result, the promise of Part A buy-in remains unrealized for these older New Yorkers.

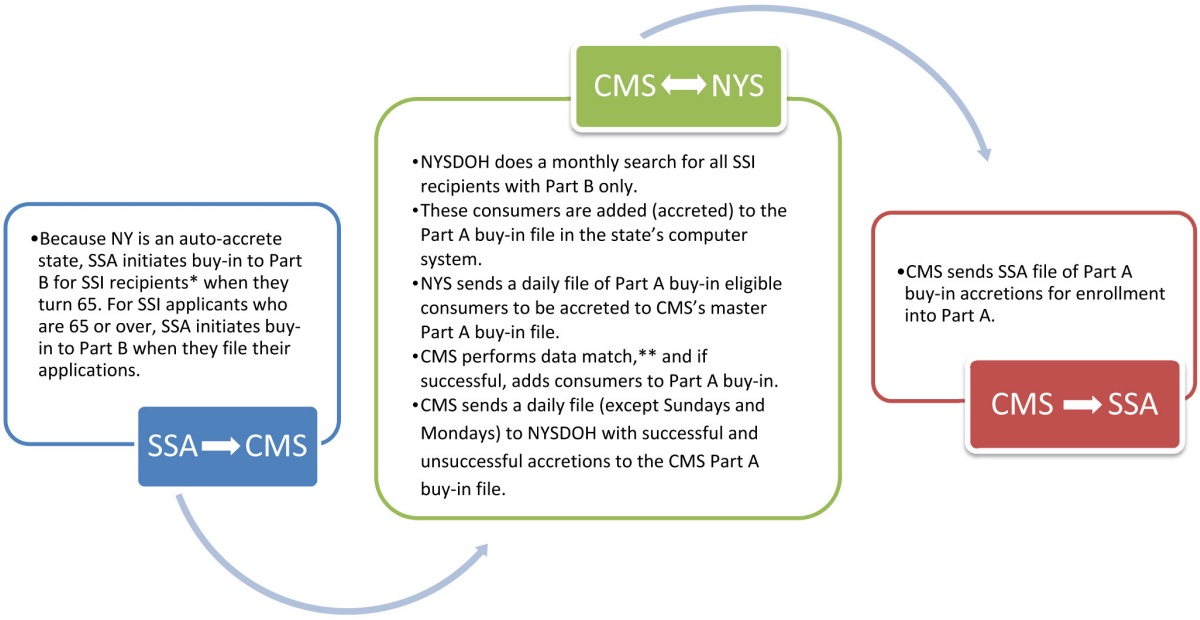
Automated Enrollment Procedures for Persons with SSI

New York's Part A buy-in agreement, working in concert with other proactive measures, has enabled the state to automate and vastly simplify Part A buy-in enrollment processes for older New Yorkers who receive SSI. New York's "1634" or "auto-accrete" agreement with SSA, coupled with its Part A buy-in agreement, allow the state to enroll SSI recipients in the Part A buy-in benefit without requiring that they first apply for Medicare through SSA or submit a QMB application to the state. SSI applicants apply for benefits through their local SSA offices. In the 26 auto-accrete states, Medicaid agencies accept a determination of SSI (and state supplement) eligibility as a determination of Medicaid eligibility.[44] In addition, SSA automatically screens SSI recipients in auto-accrete states for Medicare eligibility and enrolls them in Part B when they qualify.[45] After SSA enrolls an SSI recipient in Part B, New York has authority under its Part A buy-in agreement to add the individual to the Part A buy-in file without an additional Medicare application or QMB application from the individual. Since adopting its Part A buy-in agreement in 2004, DOH routinely screens Medicaid rolls on a monthly basis and enrolls persons with Part B but not Part A to the Part A buy-in file. [46]

In summary, three key elements have allowed New York to automate Part A buy-in enrollment for SSI recipients so that an application for SSI also serves as an application for Medicaid, QMB and Medicare Parts A and B: (1) New York is an auto-accrete or 1634 state, which means that an SSI application also serves as a Medicare Part B application and automatically triggers Part B consideration and enrollment by SSA; (2) New York is a Part A buy-in state so it can enroll

Medicaid recipients with Part B in Part A buy-in (regardless of enrollment period) without additional effort on their part; (3) New York has instituted proactive measures to consider all SSI individuals with Part B for Part A buy-in and enroll them in the benefit without requiring that they first submit a separate application for QMB.

Figure 1. Automated Part A Buy-In Procedures for Older New Yorkers with Supplemental Security Income (SSI)



*SSA will initiate Part B buy-in for these individuals only if it can verify their age according to Social Security rules and if they are a citizen or a permanent legal resident who has continually lived in the U.S. for five years or more.

** For data match to be successful, all of the state's personal identifiers for consumers (e.g., first three letters of first name and first six letters of last name and Health Insurance Claim Number) must precisely match those in CMS's system.

States must implement all three of these measures to achieve automation of Part A buy-in for SSI individuals. For example, when New York was an auto-accrete but not a Part A buy-in state, the Medicaid agency lacked the authority to accrete SSI recipients to Part A buy-in even though they had Part B. Thus, SSI recipients needed to file a separate application for Medicare Part A before the state could accrete them to the Part A buy-in file. Similarly, if a state has a Part A buy-in agreement but is not an auto-accrete state, SSA will not automatically screen SSI recipients for Part B. As a result, the state cannot accrete SSI recipients to the Part A buy-in file until they have applied for Medicare through SSA. Finally, if a state has both auto-accrete status and a Part A buy-in agreement, but does not institute proactive steps to detect Medicaid recipients with Part B

only and to enroll them in Part A buy-in, SSI recipients may not obtain Part A buy-in until they file a separate QMB application with the state.[47] As discussed below, while the state automatically enrolls Medicaid recipients with SSI and Part B in Part A buy-in, it does not apply this protocol to non-SSI Medicaid recipients. As a result, non-SSI Medicaid recipients with Part B must file a QMB application or rely on their LDSS or HRA to enroll them in Part A buy-in at their yearly renewal.

Benefits of Automated Procedures

Streamlining and automating Part A buy-in for SSI recipients is cost-effective and has vastly improved Part A buy-in participation in New York State. In 2004, New York Medicaid estimated annual net local and state savings of $75 million by enrolling eligible individuals in Part A through the buy-in process.[48] Further, New York's buy-in rolls experienced a huge spike after the state implemented the automated procedures for persons with SSI. In June 2004, the month before New York's Part A buy-in status and monthly screenings took effect, New York had only 1,272 Part A buy-in recipients. In contrast, in July 2004, after these changes had been implemented, Part A buy-in enrollment jumped to 92,926, a 7300 percent increase from the prior month.[49] It appears that most of the increase came from enrolling people who previously had SSI and Part B but not Part A, thus confirming the value of the new automatic enrollment procedures.[50] Further, in the intervening six years, Part A buy-in enrollment has remained relatively stable with 99,806 individuals enrolled in June 2010.[51] It is therefore reasonable to conclude that the effectiveness of automated enrollment reforms persist over time.

Despite the positive effects of these automated reforms, underlying systems problems dilute their efficacy. As discussed more fully below, Part A buy-in enrollment depends on successful data exchange between state and federal government systems, but the technology used is antiquated and difficult for states and local governments to trouble-shoot. As a result, Part A buy-in accretions can fail and enrollment can be significantly delayed. Not only do these problems affect the SSI population in New York, but they also impair the two-step application process needed to enroll older New Yorkers without SSI, to which we will now turn.

Part A Buy-In Enrollment Process for Non-SSI Individuals in New York State: Doing the Two-Step

Although extremely helpful to SSI recipients, New York's Part A buy-in agreement and other policies have not measurably improved the Part A buy-in application process for older New Yorkers without SSI. As mentioned earlier, the Part A buy-in agreement allows states to accrete persons to the Part A buy-in file only if SSA has already determined them eligible for Medicare. In contrast to SSA's procedures for SSI individuals in New York, SSA does not automatically enroll non-SSI persons in Medicare unless they have enough work history to qualify for premium-free Part A and already receive Social Security Retirement benefits. This makes automation more challenging, because persons without premium-free Part A must first be determined eligible for Medicare before the state can enroll them in Part A buy-in. Further, while New York's efforts to ease QMB requirements have simplified enrollment for many eligible persons, these reforms have not fully addressed the problems faced by many people who lack premium-free Part A. As a result, in order to obtain Part A buy-in, many New Yorkers who lack premium-free Part A and who do not qualify for SSI must undergo a grueling two step-application process that involves (1) applying first for Medicare through SSA and then (2) applying for QMB through their LDSS or HRA office.

Non-SSI individuals who qualify for Part A buy-in include:

- Persons with neither Medicaid nor Medicare ("the uninsured")
- Medicaid recipients with no Medicare
- Medicaid recipients with Part B only
- Persons with Part B only

This section explains the process and identifies the challenges it poses. The process is reflected in Figures 2 and 3.

Consumer-Initiated Application Process for Non-SSI Individuals

Step One: Apply for Medicare through SSA

Uninsured individuals and those with Medicaid but no Medicare must first enroll in Medicare at their local Social Security office before they can apply for QMB benefits through their local Medicaid office. Persons with Part B already—that is, persons with Part B only and Medicaid recipients with Part B only—can skip step one and move directly to the second step in the process. They may apply for QMB at the LDSS because their Medicare eligibility has already been established, and New York's Part A buy-in agreement permits New York to enroll them in Part A buy-in.

At the Social Security office, SSA agents do not screen premium-Part A applicants for Part A buy-in or other low-income programs, such as Extra Help. However, if premium-Part A applicants affirmatively indicate that they may qualify for QMB, SSA agents should enroll them in Medicare Part B and "conditional" Part A at any time of the year, regardless of enrollment periods.[52] SSA agents should then refer consumers to their LDSS office to complete a QMB application. Part A, with its requisite premium, will go into effect only if and when they enroll in QMB.[53]

Finally, to prompt Medicaid recipients to enroll in Medicare, the DOH sends Medicaid recipients who are turning 65 a letter that instructs them to apply for Medicare as a condition of continued Medicaid eligibility.[54] The letter also advises them to contact their LDSS to see if they qualify for the MSPs to help pay their Medicare costs. People who are uninsured or who have Medicaid and recently qualify for Medicare based on meeting the US citizenship or five-year residency requirement do not receive this notification or other communications instructing them to apply for Medicare or a MSP.[55]

Step Two: Apply for QMB Through the LDSS

After enrolling in Medicare at SSA, individuals should complete a QMB application at their LDSS. In order to apply, individuals must furnish their Medicare card or receipt from SSA showing their Medicare enrollment. (Applicants can also complete the mail-in QMB form, but most still apply in person at their LDSS.) If applicants request only full Medicaid, the LDSS

worker should still screen them for QMB and Part A buy-in eligibility.[56] However, many workers fail to screen for this relatively unknown program and automated eligibility systems do not include prompts or safeguards to ensure that workers screen persons for QMB or the Part A buy-in benefit.

The local office should process the QMB application to pay for premiums for Medicare Part A in addition to B and accrete people to the Part A and B buy-in files. As explained below, if data transfers between the state and federal government proceed without glitches, the person will be enrolled in Part A buy-in. In New York, QMB is effective the first of the month following the month of application.[57] Consumers who enroll in QMB may be billed for interim Part B premiums before QMB's effective date, but their Part B will not be terminated for failure to pay premiums.[58]

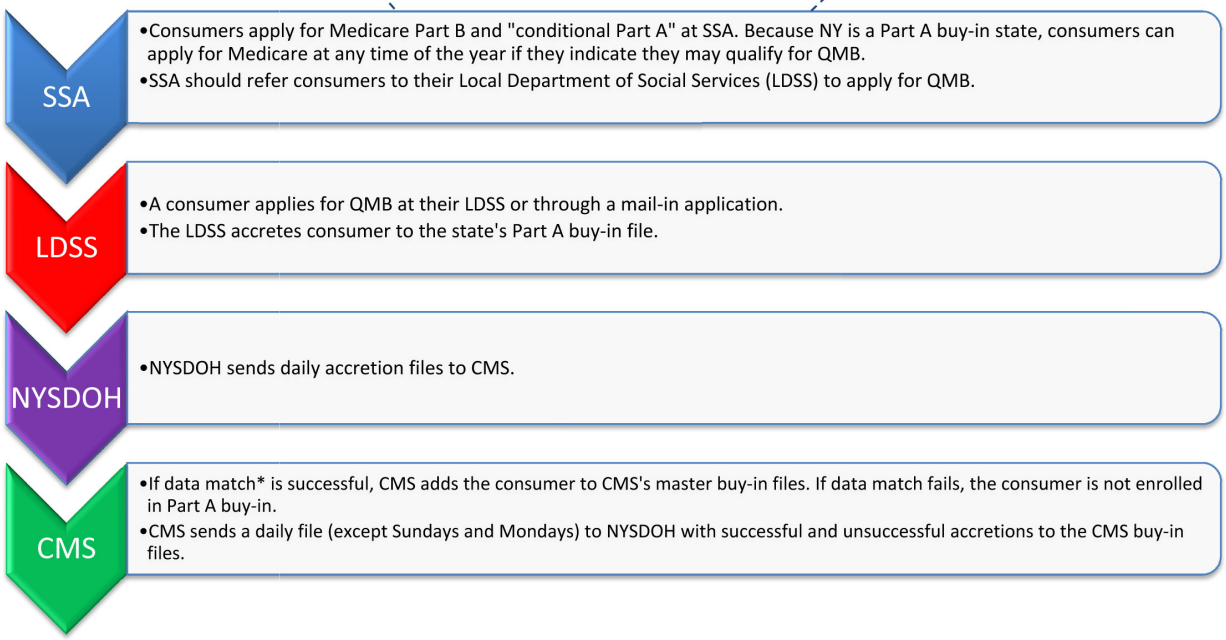
It is important to note that if individuals make the mistake of trying to apply for Medicaid or QMB through their LDSS or HRA office (step two) before they have enrolled in Medicare through SSA (step one), the worker will not allow them to apply for QMB at that time. Those individuals can only apply for QMB after they make a separate trip to SSA to enroll in Medicare.

Additionally, just as for its Medicaid recipients with SSI and Part B, the state has the authority under its Part A buy-in agreement to accrete non-SSI Medicaid recipients with Part B to the Part A buy-in file without a QMB application. But DOH, in contrast to how they process SSI individuals, has not implemented automated procedures to enroll non-SSI Medicaid recipients with Part B in Part A buy-in. Instead, those individuals with non-SSI Medicaid and Part B must submit a new Medicaid or QMB application or wait until their yearly renewal to be considered for Part A buy-in by a local worker.[59]

Figure 2. Consumer-Initiated Part A Buy-In Process in New York for People Without Medicare

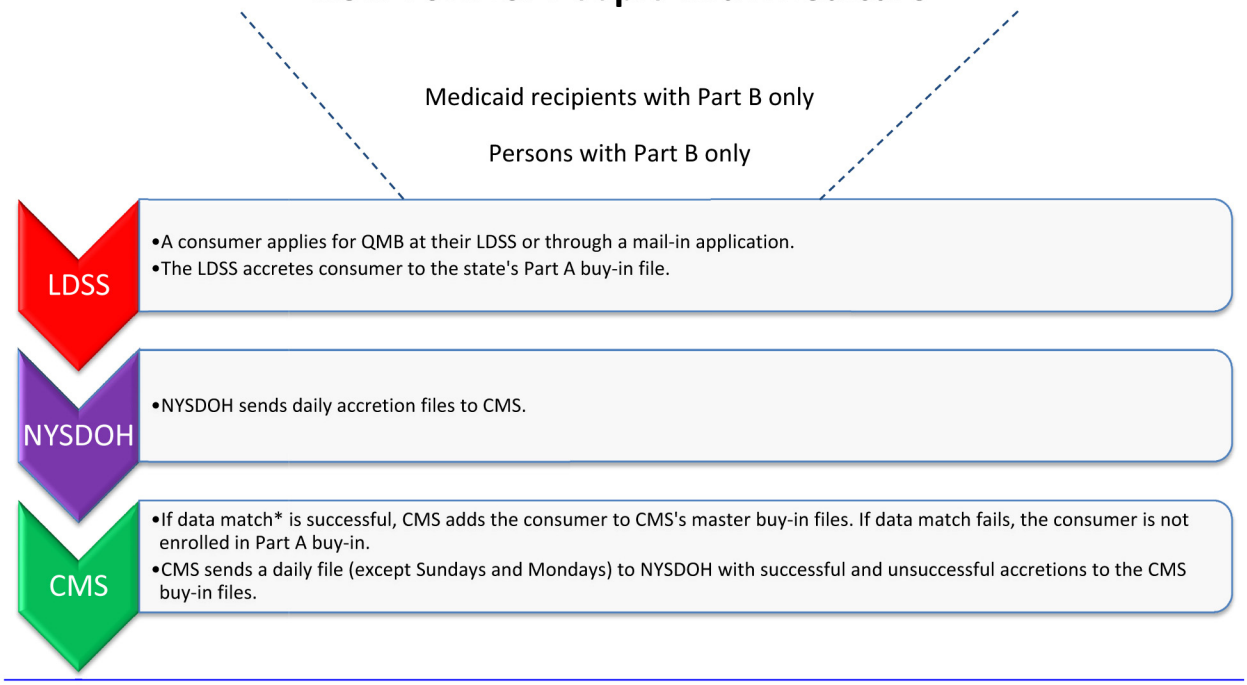
Persons with neither Medicaid nor Medicare ("the uninsured")

Medicaid recipients with no Medicare



* For data match to be successful, all of the state's personal identifiers for consumers (e.g., first three letters of first name and first six letters of last name and Health Insurance Claim Number) must precisely match those in CMS's system.

Figure 3. Consumer-Initiated Part A Buy-In Process in New York for People with Medicare



* For data match to be successful, all of the state's personal identifiers for consumers (e.g., first three letters of first name and first six letters of last name and Health Insurance Claim Number) must precisely match those in CMS's system.

Barriers to Participation in Part A Buy-In

As illustrated by the accompanying case examples below, the consumer-initiated Part A buy-in process is virtually impossible for most persons to navigate. First, according to a substantial body of research, lack of awareness of the Medicare Savings Programs and complicated enrollment processes constitute the leading obstacles to participation. [60]

Case Example of Ms. Y

Ms. Y, a 69-year-old legal immigrant from Japan with limited English proficiency (LEP), was uninsured and did not qualify for premium-free Part A. She had multiple health problems, and she could not afford to visit the doctor or purchase her prescription drugs. Medicare Rights helped her enroll in the New York State Pharmaceutical Assistance Program (SPAP), or the Elderly Pharmaceutical Insurance Coverage program (EPIC), for which she was eligible, but she needed access to affordable medical care.

Her son, a dietician, asked multiple entities, including 1-800 Medicare, the SSA local office, the LDSS and community-based organizations, whether his mother could qualify for Medicare, but was incorrectly informed that she could not enroll in Medicare because she did not have the work history to be eligible for premium-free Part A. He was also informed that she could come back and enroll during the General Enrollment Period but would have to pay upwards of $600 per month in premiums alone. Neither she nor her son had sufficient income or resources to afford such an expensive premium.

Based on a friend's referral, Ms. Y's son contacted Medicare Rights, which informed him about the Part A buy-in process, explained it in great detail and what to expect at each stage, and provided him with a hand-out that outlined the steps they needed to take. Ms. Y and her son first visited their local SSA office in June so that she could enroll in Medicare. At the local SSA office, the agent was unaware of the Part A buy-in benefit and did not understand Ms. Y's request to enroll in it. The agent refused to process her Medicare enrollment because it was outside of the General Enrollment Period. Ms. Y's son called a Medicare Rights caseworker, who intervened to convince the New York Regional Social Security Office to reach out to the local office in order to set up a separate appointment and help enroll Ms. Y in conditional Part A and Part B.

A few weeks after Ms. Y received her Medicare card, she and her son went to their LDSS office, the Human Resources Administration (HRA) to apply for QMB. Instead of processing her Part A buy-in enrollment and a QMB application, the LDSS worker, who was not familiar with the Part A buy-in

program, processed an application for Medicaid and not QMB or Part A buy-in. As a result, Ms. Y received full Medicaid benefits but did not receive the Part A buy-in benefit. She was unable to pay bills for the Part B premium and was threatened with termination. Until this time, Ms. Y and her son were under the impression that they had filed for QMB and been enrolled in Part A buy-in, along with Medicaid, and trusted that the LDSS worker had screened her for all benefits.

Three months later, Ms. Y and her son returned to the LDSS and were informed that she had never applied for QMB because the LDSS worker that processed her Medicaid application never filed a QMB application. At that point in time, the receptionist gave her a blank application form and told her to apply. After intervention by a Medicare Rights caseworker, the local office agreed to back-date her QMB application to the date of her Medicaid application. Additionally, Medicare Rights convinced the local SSA to continue her Part B coverage pending her QMB eligibility determination.

Case Example of Ms. T

Ms. T had Part B when she applied for Medicaid. LDSS enrolled her in Medicaid but did not screen her for QMB or Part A buy-in eligibility. Medicare Rights submitted a QMB application on her behalf in October 2008. In January 2010, she received a denial notice stating that she must first have Part A to enroll in QMB and that she should contact her local Social Security office to apply. A Medicare Rights caseworker asked the LDSS to accrete Ms. T to Part A buy-in since she already had Part B and was eligible for QMB. Ms. T was subsequently accreted to Part A buy-in without needing to apply for Part A at the Social Security office.

Yet, the Part A buy-in enrollment procedure requires that eligible persons understand and be able to navigate a very complicated enrollment process and understand jargon that can sound like a foreign language. For example, SSA does not routinely explore whether premium-Part A applicants may qualify for QMB. It is up to individuals or their representatives to affirmatively indicate they may qualify for QMB and request enrollment in Part B and conditional Part A outside of the General Enrollment Period. Applicants must be equipped to explain the intricacies of this process if an agent is not familiar with it. Moreover, as mentioned earlier, for the uninsured and for Medicaid recipients who lack Medicare, the Part A buy-in process is particularly hard to grasp and navigate because it requires that applicants submit two separate applications to two separate bureaucracies in a precise sequence. Multistep application processes like those for Part A buy-in are especially arduous and unrealistic for low-income populations.[61] These obstacles are exacerbated for applicants when they are immigrants with limited English proficiency (LEP) like Ms. Y (see case example on pp. 22–23). Studies indicate that people with LEP experience even greater difficulty navigating low-income enrollment processes.[62] Moreover, they may distrust government and be reluctant to respond to government outreach unless approached in partnership with a trusted entity, such as a local community-based organization.[63]

Further, lack of knowledge about the Part A buy-in benefit among staff in government agencies and other entities undermines the ability of persons to enroll in the Part A buy-in benefit. Given the complexity of the enrollment process and the relatively small number of affected individuals, it is very difficult to educate and sustain knowledge over time among frontline and other government workers. The case examples illustrate that pervasive unawareness of Part A buy-in —among the customer service representatives at 1-800-Medicare, the frontline staff at community-based organizations, SSA and LDSS offices. Lack of knowledge by workers can halt low-income enrollment processes in their tracks.[64] Eligibility-screening systems with automated prompts that remind workers to consider persons for all public benefits for which they may qualify are not in use in New York and many other states.

Considering the difficulties inherent in the Part A buy-in application process for eligible individuals, outreach efforts, such as the letter to Medicaid individuals turning 65, may yield few QMB enrollments because very few people can successfully navigate this byzantine enrollment process.

System Problems That Undermine Buy-In Program Reforms

While the Part A buy-in enrollment process for older New Yorkers without SSI is in desperate need of streamlining to increase access to the MSPs, lack of adequate technology and onerous systems data-matching requirements can also inhibit Part A buy-in enrollment and undermine measures designed to increase enrollment. These problems affect persons without SSI but also threaten improvements made for the SSI population.

Part A buy-in enrollment hinges on successful information transfer between state and federal Medicaid data systems. Under Part A and Part B buy-in agreements, states are responsible for transmitting the names of eligible persons to CMS for addition ("accretion") to CMS's buy-in files. States can exchange buy-in data with CMS as frequently as once per day and as infrequently as once per month. In 2005, New York began exchanging buy-in data with CMS on a daily rather than a monthly basis (except on Sundays and Mondays, when CMS does not send data). By moving to a more frequent data exchange schedule, New York has enabled persons to receive benefits more quickly. As of December 30, 2010, New York and 16 other states exchange data with CMS on a daily basis.[65]

While increasing the frequency of data exchange has helped to speed the receipt of benefits for many older New Yorkers, delays still persist due to data mismatches between the federal and state systems. Before the CMS buy-in file will accept a Part A buy-in accretion submitted by the state, all of the state's personal identifiers for individuals must precisely match CMS's personal identifiers.[66] CMS's data match requirements are stringent. For example, the first three letters of the person's first name, the first six letters of the person's last name and the person's Health Insurance Claim (HIC) number must be identical. Any discrepancies between state and federal personal identifiers will cause CMS to reject an individual's buy-in accretion. CMS sends a list of "rejected records" to the state to correct and resubmit to CMS.

Case Example of Ms. D

In July 2008, Medicare Rights checked with CMS and was advised that Ms. D did not have Medicare Part A even though she had SSI and her Part B premium was paid by the state. Medicare Rights brought Ms. D to the attention of local LDSS staff, who agreed to add her to Part A buy-in. However, in July 2009, Medicare Rights sent the LDSS a request for follow-up because Ms. D was still not receiving Part A benefits. The LDSS reconfirmed Ms. D's Part A buy-in enrollment on several subsequent occasions, but CMS had no record of her enrollment. It was not until the following year—in 2010—that CMS's records reflected Ms. D's enrollment in Part A buy-in.

Ms. D's case demonstrates how system incompatibilities can derail enrollment and undermine critical program reforms.[67] Even if state systems reflect Part A buy-in, individuals will not receive the benefit if CMS systems reject the file sent by the state. In New York, LDSS and HRA offices are responsible for correcting rejected buy-in records and for sending the corrected information back to the state for transmission to CMS. Specialized knowledge and significant staff resources are needed to correct the errors because the rejected records do not identify why the information does not match or how it should be corrected. Local workers must use "trial and error" to correct the records until the state and federal records match and Part A buy-in accretion can take effect.

Recommendations to Promote Part A Buy-In Participation in New York

This section suggests several potential reforms to address the above-mentioned barriers to the Part A buy-in processes and to more fully realize the promise of the Part A buy-in benefit in New York.

1) Simplify and automate the Part A enrollment process for non-SSI individuals.

Given the proven track record of automated enrollment processes that depend on little or no action by consumers, participation in public benefit programs in general and in Part A buy-in in particular would be greatly improved by automating the Part A buy-in application process for persons without SSI. Automation should involve the following reforms:

a. Together with SSA, New York should adopt a "no-wrong-doors policy" to eliminate the two-step application process for the uninsured and for persons with Medicaid but no Medicare. The Part A application process should be simplified to entail one, rather than two, applications for the uninsured and for persons with Medicaid but no Medicare. To that end, SSA and New York should share information and coordinate efforts to create a "no-wrong-doors policy" to benefits. Because Part A buy-in requires a multistep application process, uninsured consumers who do not know that they are eligible for Part A buy-in may first seek to access health care coverage at the wrong office or not know how to articulate what they need. It is critical to ensure that, no matter where a consumer first goes, they will be screened for Part A buy-in and enrolled without the need to complete additional applications.

Creating a no-wrong-doors policy for Part A buy-in will require the following reforms.

i. Existing data-sharing between SSA and states should be employed to allow persons who apply for Medicare at SSA to enroll in the Part A buy-in benefit without the need to make a separate trip to the Medicaid office.

- As required by the Medicare Improvements for Patients and Providers Act (MIPPA), SSA already sends Extra Help information to the state for MSP determinations.[68] While SSA screens all Medicare End-Stage Renal Disease (ESRD) and Social Security Retirement applicants for Extra Help, it does not do so for people who apply for premium-Part A.[69] If SSA changed its procedures to screen all premium-Part A applicants for Extra Help, such Extra Help application data could be sent to the state for an MSP determination, including Part A buy-in.

- In 2011, New York's State Enrollment Center will assume responsibility for MSP determinations based on SSA Extra Help data, including Part A buy-in.[70] This promises to cut out additional layers of bureaucracy, reduce administrative expense and impose greater quality control.

- CMS and SSA should work with New York and other states to help ensure that Extra Help data sent from SSA is useable and sufficient to allow MSP determinations without additional follow-up. To the extent that SSA data is incomplete, the state should work with the federal government to enable the state to maximize the use of third-party data sources to obtain any outstanding information rather than contacting the individual. For example, New York could use data from state tax returns and programs with comparable eligibility requirements, such as food stamps and EPIC, to determine if people are eligible for the Part A buy-in program.[71]

  - If persons do not wish to apply for Extra Help, SSA should still proactively ask whether they would like to be considered for QMB. Ideally, SSA would collect financial information and send this to the state for an MSP determination with an applicant's permission. At a minimum, SSA could send applicants' names and addresses to the state for consideration of QMB. As mentioned above, in making MSP determinations, the state should use third-party data to minimize the need for additional follow-up with the individual.

ii. *If applicants first apply for QMB before they have obtained Medicare, the state should share applicants' data with SSA to screen for Medicare and eliminate the need for individuals to apply for Medicare through SSA and then circle back to apply for QMB***.**

  - As mentioned earlier, centralizing Part A buy-in eligibility determinations will facilitate such information sharing.

  - DOH and SSA are currently exploring the utility of sharing information using this approach. For example, in summer 2010, New York sent information for several Medicaid recipients to SSA for a Medicare eligibility determination. These

individuals appear to have met Medicare residency and citizenship requirements, but do not seem to have applied for Medicare through SSA.[72]

Streamlining the Part A buy-in application process comports with recent federal efforts to ease enrollment into the MSPs and other low-income programs. For example, it builds on existing MIPPA data transfers. Also, under the Affordable Care Act (ACA), states must coordinate application processes for Medicaid, SCHIP and the new exchange plans for persons under 65 so that there is no wrong door into coverage, allow for online application submission and maximize the use of third-party data to determine persons eligible for benefits.[73] These system modernizations and streamlined enrollment processes offer much promise for boosting enrollment in low income health programs, including those for the Medicare population.

b. New York should take additional steps to ensure Medicaid recipients with Part B only and QMB applicants with Part B are added to Part A buy-in with minimal effort on the part of individuals.

i. DOH should adopt new policies to ensure that Medicaid recipients with Part B only do not need to wait until renewal or file a separate QMB application to obtain Part A buy-in. To that end, just as it does for the SSI population, DOH should routinely screen Medicaid recipients with Part B only for Part A buy-in and enroll them in the program without requiring them to submit a separate QMB application.

ii. DOH should ensure that QMB and Medicaid applicants who already have Part B are enrolled in Part A buy-in without requiring them to first apply for Part A through SSA. As detailed above, while New York's Part A buy-in agreement allows local workers to enroll applicants with Part B into Part A buy-in, many workers are not familiar with Part A buy-in and may send applicants to SSA to apply for Part A first. Expanding the role of New York's State Enrollment Center or DOH to administer all Part A buy-in eligibility determinations could impose greater quality control since it is difficult for busy case workers to stay knowledgeable about this specialized and relatively small program. As mentioned below, however, local workers will still need education to refer cases to the state for eligibility determinations.

2) **Data exchanges between CMS and the state could be improved to ensure automated reforms remain effective**. Frequently neglected but of critical importance are problems related to data-sharing between the state and federal government. These must be addressed, because system glitches will undermine the effectiveness of program reforms.

    - Ideally, the state and CMS would update buy-in systems and incorporate them into new computer systems built to handle increased use of third-party data under ACA. In the interim, CMS must relax data exchange requirements to make it easier for New York and other states to accrete people to CMS's master Medicare buy-in files.[74] As it currently does with Extra Help, CMS should limit the number of personal identifiers that need to match between state and federal systems to reduce data mismatches and benefit delays.

    - CMS should also notify auto-accrete states that they can request that SSA expand their 1634 agreements to enroll SSI recipients into Part A at the same time the agency enrolls them into Part B. This would eliminate the need for the state to transmit Part A buy-in data to CMS for this population, thereby reducing the likelihood of data exchange problems. It would also eliminate the need for and costs associated with DOH's monthly searches to identify these SSI individuals with Part B and enroll them in Part A buy-in.

3) **Provide extensive training regarding Part A buy-in reforms to front-line staff and 1-800 MEDICARE.** Even if Part A buy-in processes are simplified and centralized, workers will still need extensive training and retraining to identify persons who may qualify for Part A buy-in and to make appropriate referrals to the state .

4) **Educate community groups and benefit specialists about Part A buy-in processes and involve them in government outreach efforts.** Studies show that, especially for people with LEP and people with limited education, community groups with knowledge about programs are trusted sources of information and can be very effective in helping low-income people get enrolled in programs.[75] Targeted outreach to low-income populations by government agencies in partnership with community groups represents an extremely effective way to reach underserved populations. [76]

Lessons for Other States

While this report focuses on New York, the recommendations and lessons learned apply to all states. For example, the above recommendations to streamline enrollment processes, improve education of government workers and enlist community-based organizations hold much promise for improving enrollment for non-SSI individuals in other states. These measures will gain the most traction if states have taken complementary efforts to otherwise ease QMB enrollment barriers, as New York and many other states have done, since these reforms help simplify the application process, allow more persons to qualify and reduce administrative costs associated with processing MSP applications.[77] In addition, these reforms will work only if states have adopted a Part A buy-in agreement to address problems caused by the structure of the Part A buy-in benefit.

Of equal importance but often overlooked, states must improve their data systems, and CMS must relax data restrictions to avoid diluting the efficacy of reforms. States can exchange data with CMS on a daily basis, as New York and 16 other states currently do, to avoid delays in people getting benefits. In addition, states could significantly boost Part A buy-in enrollment for those with SSI by adopting all three key measures—(1) auto-accretion, also known as 1634 agreements (SSI application also serves as a Medicare Part B application and automatically triggers Part B consideration and enrollment by SSA); (2) Part A buy-in agreements (can enroll Medicaid recipients with Part B in Part A buy-in); (3) consider all SSI individuals with Part B for Part A buy-in and enroll them without requiring a separate application for QMB first—implemented by New York to automate enrollment for these individuals, including the Part A buy-in agreements. Currently, only 23 states have both Part A buy-in and 1634 agreements.[78] In the wake of recent litigation settled in 2010, Pennsylvania, a state with both federal agreements, began automating Part A buy-in enrollment for those with SSI by enrolling SSI recipients with Part B in Part A buy-in on a monthly basis. Also, as New York did in 2005, Pennsylvania moved to exchange buy-in data with CMS on a daily rather than monthly basis.[79] We do not know how many other states besides New York and Pennsylvania have adopted data system reforms and each of the three essential measures to automate Part A buy-in enrollment for their SSI recipients. Further research is needed to help identify the most proactive states.

Federal efforts to outline program requirements, identify best practices, and to track enrollment rates have resulted in enrollment gains for the MSPs and the children's health programs in the past.[80] A new CMS initiative to outline requirements under federal law and to recommend reform could prompt states to employ new policies to promote Part A buy-in participation. As part of this effort, CMS should consider whether it has the authority to enroll eligible persons in the Part A buy-in benefit if the state has failed to enroll them in the program. Alternatively, CMS should explore whether federal requirements that all states offer QMB means that all states must adopt key reforms, such as the Part A buy-in agreement, to ensure that persons without premium-free Part A can actually obtain QMB. Enrolling in Part A buy-in in the 14 group-payer states is virtually impossible due to the barriers stemming from the structure of the Part A buy-in benefit. The need for reform holds particular importance in light of new CMS initiatives to coordinate care and health care financing for persons with both Medicare and Medicaid. These delivery system reforms will be undermined unless low-income older adults who qualify can obtain Medicare and MSPs to pay their Medicare expenses. Finally, as states revamp and streamline enrollment systems under health reform, they risk marginalizing this population unless they also retool the systems that serve them.

[1] In 2006, the average Medicare beneficiary spent $4,241 out of pocket in Medicare premiums and medical and long-term care costs. Kaiser Family Foundation, *Medicare Chartbook*, Fourth Edition, 2010, at http://facts.kff.org/chartbook.aspx?cb=58. In 2011, the Part B premium will vary depending upon an individual's circumstances. In 2011 individuals with incomes below $85,000 ($170,000 for couples) will be paying one of three different Part B premiums. People who have had their premium withheld from their Social Security check since 2009 will continue to pay $96.40 each month for Part B. People who enrolled during 2010 and had their premiums deducted from their Social Security check and people who began having their premiums deducted from their Social Security check in 2010, will continue to pay $110.50. New enrollees and people who do not have their premiums deducted from their Social Security check will pay the 2011 Part B premium, which is $115.40. The Part B premium for individuals who earn more than $85,000 ($170,000 for couples) will be higher and based on their income.

[2] Medicare beneficiaries do not need to pay a premium for Part A if they are disabled (qualify for Social Security Disability Insurance [SSDI]) and either do not work or it has been 8½ years or less since they returned to work. After 8½ years, if they are still disabled, they can still participate in Medicare, but they must pay the Part A premium.

[3] Michael Birnbaum and Elizabeth M. Patchias, "Measuring Coverage for Seniors in Medicare Part A and Estimating the Cost of Making It Universal," *Journal of Health Politics, Policy and Law* 35 (1) (February 2010) at http://www.uhfnyc.org/publications/880647 [hereinafter "Measuring Coverage for Seniors in Medicare Part A"].

[4] 42 CFR Sections 406.5, 406.20; SSA Program Operations Manual Systems (POMS) HI 801.140.

[5] Certain groups are excluded from Social Security payroll taxes. For example, certain domestic and farm workers and self-employed persons are excluded if they have low yearly earnings. *See* Social Security Administration, *Annual Statistical Supplement 2007* at http://www.socialsecurity.gov/policy/docs/statcomps/supplement/2007/oasdi.pdf. Additionally, according to the U.S. General Accounting Office, certain employers fail to pay Social Security payroll taxes that are owed. The main industries with unpaid payroll tax obligations include: construction, professional services, health care, manufacturing, sales, food services, transportation and warehousing. See General Accounting Office, *Businesses Owe Billions in Federal Payroll Taxes*, GAO-08-617, July 2008, at http://www.gao.gov/new.items/d08617.pdf.

[6] *See* Centers for Medicare & Medicaid Services, *Medicare and You 2011*, p. 91. *See also* 42 C.F.R. Sections 406.26, 407.40. Under buy-in agreements, states can elect to pay Medicare premiums for Medicaid recipients who also qualify for Medicare.

[7] 42 U.S.C. Section 1396d(p)(1).

[8] SSA Section 1902(r)(2).

[9] New York State amended its state Medicaid plan so that it does not consider assets in determining financial eligibility for MSPs. *See* State of New York, Office of Health Insurance Programs, GIS 08 MA/016, "Elimination of

the Asset Test for the QMB and SLIMB Programs," June 27, 2008, at http://onlineresources.wnylc.net/pb/docs/08ma016.pdf.

[10] Henry J. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities*, February 2010, at http://www.kff.org/medicaid/upload/8048.pdf.

[11] Centers for Medicare & Medicaid Services, Dual Eligible Statistics for New York.

[12] Memorandum from Gale Arden to All Associate Administrators Re: Medicare Cost-Sharing for Medicaid Beneficiaries (Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations) February 27, 2008, at http://www.medicareadvocacy.org/InfoByTopic/MedicareSavingsPrograms/MedSavProg_08_04.24.ARABalanceBilling.pdf.

[13] Alex D. Federman, Bruce C. Vladeck and Albert L. Siu, "Avoidance of Health Care Services Because of Cost: Impact of the Medicare Savings Program," *Health Affairs* 24 (1) (January/February 2005). Available at http://content.healthaffairs.org/content/24/1/263.full.

[14] 42 CFR Sections 423.34; 423.773

[15] *See* Christina Boccuti, Kevin Hayes and Ariel Winter, *Assessing Payment Adequacy: Physician, Other Health Care Professional, and Ambulatory Surgical Care Center Services,* Medicare Payment Advisory Commission [MedPAC], December 2, 2010, at http://www.medpac.gov/transcripts/Physician%20public%20Dec%202010%20pres.pdf; Stephen Zuckerman, Aimee F. Williams and Karen E. Stockley, "Trends in Medicaid Physician Fees 2003–2008," *Health Affairs* 28 (3) (May 2009).

[16] *See* State of New York, Office of Health Insurance Programs, GIS 08 MA/016, "Elimination of the Asset Test for the QMB and SLIMB Programs," June 27, 2008, at http://onlineresources.wnylc.net/pb/docs/08ma016.pdf. Also, states are eligible to receive matching funds for these Medicare costs paid under the MSPs only if enrollees do in fact have Part A. If a state erroneously claims MSP enrollment for individuals without Part A, they are subject to federal recovery of any matching funds received.

[17] *See* Scott Dershowitz, *Local Promise: Maximizing Enrollment in Low-Income Medicare Programs Through State-Based Consumer Advocacy,* Medicare Rights Center, July 2010, at http://www.medicarerights.org/pdf/Local-Promise.pdf [hereinafter *Local Promise*].

[18] U.S. Congress. Congressional Budget Office. *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*, July 2004, at http://www.cbo.gov/doc.cfm?index=5668&type=0. This estimate does not include persons who are also eligible for full Medicaid benefits. Enrollment rates for this population are much higher.

[19] *See,* e.g., Laura Summer, *Increasing Participation in Benefit Programs for Low-Income Seniors*, The Commonwealth Fund, May 2009, at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/May/1266_Summer_increasing_particip_benefit_progs_v3.pdf [hereinafter *Increasing Participation]*; Kim Glaun, *Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs Case Study Findings,* Kaiser Commission on

Medicaid and the Uninsured, December 2002, at http://www.kff.org/medicaid/20030522-index.cfm [hereinafter *Medicaid Programs to Assist]*.

[20] 38 states allowed a mail-in MSP application with no face-to-face interview required. Patricia Nemore, Jacqueline Bender, Wey-Wey Kwok, *Toward Making Medicare Work for Low-Income Beneficiaries:A Baseline Comparison of the Part D Low-Income Subsidy and Medicare Savings Programs Eligibility and Enrollment Rules*, Henry J. Kaiser Family Foundation, May 2006, at http://www.kff.org/medicare/upload/7519.pdf.

[21] State of New York, Office of Health Insurance Programs, GIS 08 MA/016, "Elimination of the Asset Test for the QMB and SLIMB Programs," June 27, 2008, at http://onlineresources.wnylc.net/pb/docs/08ma016.pdf.

[22] Birnbaum and Patchias, "Measuring Coverage for Seniors in Medicare Part A."

[23] U.S. Census Bureau, 2008. Current Population Survey (CPS).

[24] Birnbaum and Patchias, "Measuring Coverage for Seniors in Medicare Part A." at 51 (analyzing U.S. Census Bureau's 2005 Current Population Survey (CPS) data). Among the uninsured are those who likely do not qualify for Part B buy-in, including undocumented immigrants, as well as legal immigrants who have lived in the U.S. less than the requisite five years to qualify for Medicare.

[25] *Id*. at 52. The Part B-only group likely includes persons who qualify for the Part A buy-in benefit, but may also include groups that do not qualify, such as older adults with incomes too high to qualify for QMB and who are paying the premium themselves, persons enrolled in the Specified Low-Income Medicare Beneficiary program, which pays only the Part B premium for those with incomes between 100 percent FPL and 120 percent FPL, and individuals enrolled in the Qualified Individual program, which pays the Part B premiums for persons with incomes between 120 percent FPL and 135 percent FPL in New York State.

[26] *Id.* at 51. The Medicaid-only cohort may include older adults who qualify for Medicaid spend-down, which allows persons to use their medical expenses to reduce their income and qualify for full Medicaid. Some of these individuals may have income too high to qualify for the Part A buy-in benefit.

[27] For example, in a span of six months, from January 2009 through May 2010, the Medicare Rights Center (Medicare Rights) helped just under 40 eligible New York City residents with no prior health insurance to obtain Part A buy-in benefits.

[28] State of New York, Office of Medicaid Management, GIS 04 MA/013, "Medicare Part A Buy-in," July 1, 2004, at http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/04ma013 [hereinafter "GIS Medicare Part A Buy-in"].

[29] 42 U.S.C. Section 1396d(p)

[30] SSA Programs Operations Manual Systems (POMS) HI 801.131; 42 CFR Section 406.20.

[31] Patricia Nemore, *Can You Be a "Qualified Medicare Beneficiary" If you Don't Have Medicare Part A?* Center for Medicare Advocacy, October 2009, at http://www.medicareadvocacy.org/Projects/AdvocatesAlliance/IssueBriefs/09_10.19.QMBsWithoutPartA.pdf.

[32] *See,* e.g., Glaun, *Medicaid Programs to Assist.*

[33] The Initial Enrollment Period is the seven-month period including the month the person first meets all requirements for premium-Part A. 42 C.F.R. Section 406.22.

[34] SSA Program Operations Manual (POMS) HI 00801.133.

[35] *See* Health Care Financing Administration, Preamble to Final Regulation for Medicare and Medicaid: Part A Premiums and Buy-in Agreements, 56 Fed. Reg. 38074, August 12, 1991.

[36] SSA Section 1818(c)(6); 42 C.F.R Sections 406.32(d), 406.33.

[37] New York State, "GIS Medicare Part A Buy-in."

[38] *See* 42 C.F.R. Sections 406.26, 407.40. Also, if a group is included in a buy-in agreement, it must buy in for all persons, not just for individuals who incur costs.

[39] SSA Program Operations Manual Systems (POMS) HI 801.140.

[40] *Id.*

[41] *See* 42 C.F.R. Section 406.26.

[42] *See* CMS Preamble, 56 Fed Register 38074, August 12, 1991.

[43] *See* SSA Program Operations Manual Systems (POMS) HI 801.140.

[44] SSA Program Operations Manual Systems (POMS) HI Sections 815.006, 815.009.

[45] *See* SSA Program Operations Manual Systems (POMS) HI Section 810.010.

[46] New York State, "GIS Medicare Part A Buy-in."

[47] *Id.*

[48] *Id.*

[49] New York State Dual Eligible Statistics.

[50] *Id.*

[51] Centers for Medicare & Medicaid Services, "Part A and B State Buy-ins By State and Selected Eligibility Categories for the June 1010 Billing Cycle."

[52] *See* SSA Program Operations Manual Systems (POMS) HI 801.140; EM-08071.

[53] *Id.*

[54] The letter is at http://www.medicarerights.org/pdf/DOH_aging_into_medicare_letter.pdf.

[55] As of July 29, 2010, there were 23,789 Medicaid individuals age 65 or older who had no Medicare and had been on Medicaid for at least five years since they turned 65. DOH could not certify whether they met Medicare's continuous five-year residency requirement.

[56] *See* New York State, "GIS Medicare Part A Buy-in."

[57] *Id.*

[58] SSA Program Operations Manual Systems (POMS) HI 01001.205, at http://policy.ssa.gov/poms.nsf/lnx/0601001205

[59] *See* New York State, "GIS Medicare Part A Buy-in."

[60] *See,* e.g., Summer, *Increasing Participation in Benefit Programs*; Glaun, *Medicaid Programs to Assist.*

[61] For example, Medicare beneficiaries have reported being confounded by the two-step process required in applying for LIS and a Part D plan. Debra Lipson, Allison Barrett, Angela Merrill and Noelle Denny-Brown, *Doors to Extra Help: Boosting Enrollment in the Medicare Part D Low-Income Subsidy*, AARP Public Policy Institute, September 2007.

[62] *See,* e.g., Glaun, *Medicaid Program to Assist*.

[63] *See* e.g, Kim Glaun, Medicaid Programs to Assist Low Income Medicare Beneficiaires: Working Paper on Medicare Savings Programs in Washington Kaiser Commission on Medicaid and the Uninsured, December 2002 at pgs 14, 20 at http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14339.

[64] *See,* e.g., Glaun, *Medicaid Programs to Assist,* at 21.

[65] These states are: Arkansas, Colorado, Idaho, Illinois, Indiana, Kentucky, Maryland, Massachusetts, Missouri, Montana, Nebraska, New Jersey, Ohio, Pennsylvania, South Carolina and Utah. Georgia intended to begin daily data transfers in February, and Maine, North Dakota, New Mexico and Wyoming also had plans to adopt daily data exchanges in the future. *See* Brett Coughlin, "MACPAC Urged To Examine QMB Program," *Inside CMS,* December 30, 2010.

[66] Personal conversations with Department of Health officials Robin Ikler, Mary Houlihan and Bill Emory on May 25, 2010.

[67] *See,* e.g., Glaun, *Medicaid Programs to Assist.*

[68] Medicare Improvements for Patients and Providers Act (MIPPA) P.L. 110-275, Section 113, amending 42 U.S.C. Section 1396u-5(a)(4). *See also* Center for Medicaid and State Operations, Centers for Medicare & Medicaid Services (CMS), "State Medicaid Director Letter re: Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)," SMDL# 10-003, February 18, 2010, at http://www.medicareadvocacy.org/InfoByTopic/MedicareSavingsPrograms/MIPPASMDLetter1-19-10.final.pdf

[69] *See* SSA Program Operations Manual Systems (POMS) HI 03010.005

[70] New York State, *Medicaid Administration Report*, November 2010.

[71] *See* Jennifer Edwards, Jodi Bitterman, Caroline Davis and Stan Dorn, *Reducing Paperwork to Improve Enrollment and Retention in Medicaid and CHIP,* Medicaid Institute at the United Hospital Fund, October 2009, at http://www.uhfnyc.org/publications/880624.

[72] SSA is still evaluating the efficacy of using Medicaid leads to screen persons for Medicare.

[73] Patient Protection and Affordable Care Act, P.L. 111-148, Section 2201. In November 2010, CMS issued a proposed regulation to provide enhanced matching funds to states to develop and modernize their Medicaid and related enrollment systems. If these regulations are adopted, they could help states fund system improvements for the Medicare population. *See* 75 Fed. Reg. 68583, November 8, 2010.

[74] For example, CMS systems could only require that date of birth and Social Security fields match to accept individuals to the buy-in file.

[75] Glaun, *Medicaid Programs to Assist*.

[76] In 2009, the State of New York's pharmacy assistance program, EPIC (Elderly Pharmaceutical Insurance Coverage) worked with Benefits Data Trust (BDT) and the Medicare Rights Center to conduct targeted outreach to EPIC members who were denied Extra Help because of excess resources. BDT mailings generated a 40 percent response rate, much higher than the usual rate for untargeted mailings. Of the 66 percent for which data is available, 77 percent received a Medicare Savings Program.

[77] *See* Dershowitz, *Local Promise;* Glaun, *Medicaid Programs to Assist.*

[78] Arkansas, Delaware, District of Columbia, Florida, Georgia, Iowa, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Montana, New York, North Carolina, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Washington, West Virginia, Wisconsin, and Wyoming. Seven of the group-payer states have 1634 agreements: Alabama, California, Colorado, Kentucky, New Jersey, New Mexico, and South Dakota. SSA POMS HI Sections 801.140, 815.009.

[79] *See* Center for Medicare Advocacy, *Pennsylvania Lawsuit Increases Access to Medicare for Low-Income Medicare Beneficiaries* at http://www.medicareadvocacy.org/Print/2010/MSP_10_04.29.GarciaSettlement.htm

[80] *See,* e.g., Glaun, *Medicaid Programs to Assist.*