Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries:

A 1999 Update

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STATE MEDICAID BUY-IN PROGRAMS:

VARIATIONS IN POLICY AND PRACTICE

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for

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

Sixteen million Medicare beneficiaries are poor or low-income. These low-income elderly and disabled beneficiaries have greater health care needs and higher health care costs than more affluent Medicare beneficiaries, spending an average of 35% of their income on out-of-pocket health expenses.

In 1988, Congress enacted a program called the Qualified Medicare Beneficiary program to protect poor Medicare beneficiaries from Medicare's out-of-pocket health care costs. Since 1988, Congress has established additional programs to provide more limited assistance to individuals with incomes above the poverty level. The programs are generically referred to as buy-in programs, and are operated through state-administered Medicaid programs. Medicaid "buys-into" Medicare on behalf of low-income beneficiaries, paying premiums and in some instances, deductibles and co-insurance amounts.

Buy-in programs provide critical links to the health care system for low-income Medicare beneficiaries. **Yet an estimated 45% of those who are eligible for buy-in benefits in the lowest income category (up to 100% of poverty), and even larger shares among those between 100% and 120% of poverty, are not participating.** Participation rates vary significantly across the states. A 1998 report by Families USA identifies participation in the lowest income buy-in groups as ranging from 20% in North Dakota to 88% in California.

Barriers to program participation have been identified in numerous reports over the past decade: lack of effective outreach to program beneficiaries; lack of knowledge of the programs on the part of welfare workers, Social Security employees and community-based organizations; fear on the part of beneficiaries of losing assets through Medicaid estate recovery requirements; cumbersome and obstacle-laden enrollment processes that require long waits in welfare offices, face-to-face interviews, and extensive documentation of income and assets, and difficulties with language and transportation.

Although Medicare is a fully federal program with uniform eligibility requirements, a uniform package of services and a single administrative structure, buy-in benefits for Medicare beneficiaries, because they are administered through state Medicaid programs, have no such uniformity. Low-income beneficiaries are subjected to the vagaries of differing state policies and practices when they seek financial protections from Medicare's cost-sharing requirements.

Survey results identified numerous instances of state Medicaid officials and advocates reporting opposite or at least different answers to the same question. Also, reports of state Medicaid officials sometimes differed with information available from HCFA: at least 7 states reported receiving data from HCFA that the agency says it did not send. These differences may reflect the difficulty of identifying the several people within the Medicaid agency who know about different aspects of these complex programs; they may also reflect limited knowledge of the programs on the part of many, though not all, advocates. Further, it appears that efforts to increase program visibility are not fully reaching into the communities of those serving the beneficiary population.

The 1999 Update

In 1997, the National Senior Citizens Law Center, supported by the Kaiser Family Foundation, reported the results of a survey of State Medicaid directors and advocates to document state practices and policies that would affect beneficiary use of the buy-in programs. Since that time, several developments have occurred.

In the Balanced Budget Act of 1997, Congress amended the buy-in programs in two significant ways. First, it created a limited block grant to states to provide some premium protection to individuals with incomes up to 175% of poverty (Qualified Individual Program). Yet, according to the Health Care Financing Administration (HCFA) and the Urban Institute, by the end of 1998, the first year of the program, only 1% of the money set aside for this program had been used and only 3% of potential participants had been enrolled. The Act also included language allowing states to pay less than the full Medicare co-insurance rate for the poorest buy-in beneficiaries. According to our survey findings, now only 16 states pay co-insurance at the full Medicare rate, down from 31 in 1997.

In the past two years, the federal government has increased its focus on buy-in programs. HCFA has identified improved buy-in enrollment as a specific government performance goal and has established a national target of a 4% increase in enrollment by the end of fiscal year 2000. In addition, the Social Security Administration, at the direction of Congress, undertook a 9 month demonstration project in 7 states (later expanded to 12) to test what kind of assistance given at Social Security offices best affects enrollment.

In light of the extreme vulnerability of low-income Medicare beneficiaries, the recent federal legislative and administrative focus on buy-in enrollment and proposals to administer additional cost-sharing protections are vital. This report updates the 1997 profile of state Medicaid program buy-in practices and policies. It is based on a survey of 51 Medicaid Directors and at least one advocate in each state and the District of Columbia.

Findings

Outreach

❑ ***Few states undertake aggressive or targeted outreach, relying instead primarily on brochures and fliers to inform the public about their programs.*** Most states use only one or two types of outreach material, with about two-thirds of the states using mostly brochures or fliers in county welfare offices, provider offices and senior centers.

❑ ***About a dozen states report having outreach materials concerning the buy-in programs in languages other than English; only four reported having materials in additional languages other than***

Spanish. Although more than a dozen states have some materials in Spanish, the materials are applications and notices, rather than informational material to let people know of the programs' existence. A report prepared for HCFA noted that while about one-half of Hispanic Medicare beneficiaries are potentially eligible for buy-in benefits, Hispanic beneficiaries have a comparatively lower participation rate than some other groups.

❑ ***Between a third and half the states place their own eligibility workers in settings other than welfare offices to certify eligibility for buy-in programs; however, this is often only a few workers and generally only at a few hospitals. At least 11 states require face-to-face interviews at whatever location the application is taken.*** Since only state workers can certify individuals eligible for programs, it is helpful to have state workers placed in locations where potential enrollees go for other services, such as clinics, hospitals, day care centers, senior centers and nutrition sites, to eliminate a separate trip to the welfare office.

❑ ***Only about a third of the states report making eligibility screening tools available to outside agencies; about half permit others than their own eligibility workers to accept completed applications and forward them to the state.*** The application process can be facilitated by providing screening and application assistance in the locations where people go to get other services, such as meals or day care, yet few states assist community groups to help people enroll.

Enrollment

❑ ***Since 1997, many states have simplified their programs by shortening their application form.*** Use of short form applications has grown from 10 states in 1997 to 24 in 1999. Simpler applications make it easier for beneficiaries to enroll.

❑ ***Only 20 states receive data available monthly from the Health Care Financing Administration that identifies low-income individuals newly enrolled in Medicare.*** This data is the most specific identifying information available to states about potential enrollees and can serve as a source for targeted mailings. Even among those states that receive the data, only 12 use it.

❑ ***About two-thirds of states use information already in their possession to certify and enroll potential beneficiaries in the QMB program; only about one-third rely on electronic data exchange systems with the federal government to facilitate enrollment.*** States could ease the burden on beneficiaries in navigating the complex application process by relying on information available to them from other sources, but not all do.

❑ ***Only a few states allow applicants for buy-in benefits to self-certify as to the truth of information contained in their application.*** Generally, applicants must provide documentation for all the information given on their application; this can be an insurmountable obstacle, causing applicants to

abandon the process.

❑ ***While nearly all States report that they screen all Medicaid applicants for eligibility for buy-in programs, advocates say otherwise.*** In states that do not automatically screen for all benefits, the burden is left on the applicant to know and state exactly which program she wishes to apply for; moreover, those who are found to be ineligible for full Medicaid benefits might not be considered automatically for the more limited buy-in benefit.

❑ ***At least seventeen states do not have agreements with the federal government that allow them to enroll certain individuals as QMBs throughout the entire year.*** Because individuals must have Medicare Part A to be eligible as QMBs, those who do not receive Part A automatically must enroll. In states without agreements, enrollment can only be done at specific times; those who miss the enrollment period may be denied QMB benefits for as long as 14 months.

Qualified Individual Program Implementation

❑ ***Most states are making the required annual re-enrollment in the Qualified Individual program relatively easy by mailing applications or re-certification forms to current recipients for them to return.*** These policies will ease the burden on program beneficiaries.

❑ ***Only about half the states reported undertaking outreach to inform beneficiaries of the Qualified Individual program enacted in the 1997 Balanced Budget Act; few of those states designed special campaigns.***

Eligibility

❑ ***Between a quarter and a third of the states use methods of determining eligibility that are more generous than those used by the remaining states.*** More generous eligibility methods allow the program to be available to more people, since they result in higher income or resource ceilings. Alabama has eliminated the resource test altogether, making the program easier to enroll in, as applicants do not have to document their resources.

❑ ***12 states provide full Medicaid coverage to older people and people with disabilities with incomes up to 100% of poverty.*** Full Medicaid is a more substantial benefit than Medicare cost-sharing assistance only, since it covers, among other things, prescription drugs. If beneficiaries are aware they can get drug coverage, they may be more likely to seek benefits; they would then receive buy-in benefits as well.

❑ ***Less than half of the states use an income standard for families that recognizes the full size of the family.*** Instead, they adhere to the Supplemental Security Income standard that recognizes only one

or two persons in a family, making it more difficult for the sole wage earner of a larger family to qualify.

QMB Cost-Sharing Benefit

❑ ***Since passage of the 1997 Balanced Budget Act that authorized states to pay less than full Medicare co-insurance rates, fifteen states have decreased their payment rates. Now, only about a third of the states pay at the higher rate.*** In 1997, 31 states reported paying co-insurance at the full Medicare rate; in 1999, only 16 states so reported. The Medicare rate is generally higher than the state's Medicaid rate for a similar service; payment at the lower rate can restrict access to providers.

Managed Care Enrollment

❑ ***Only about a fifth of the states that have Medicare managed care plans have systems for identifying QMBs who are enrolled in them.*** To meet their cost-sharing obligations for QMBs, states need to know if QMBs receive traditional Medicare fee-for-service or are enrolled in a managed care plan, as the payment systems are different. Yet, few states have systematic ways of identifying those enrolled in managed care, relying instead on being notified by the beneficiary or by a particular provider seeking payment.

❑ ***Since 1997, many states have improved their programs by undertaking to pay co-payments for QMBs enrolled in Medicare health maintenance organizations (HMOs). Still, fewer than half of the states that have Medicare HMOs pay the co-payments, although the law requires them to do so.*** In 1997, only 6 states clearly reported paying such payments; in 1999, 19 states so reported. As noted above, however, many states do not have reliable ways of knowing who is enrolled, so that they only pay when a claim is submitted to them. This is in contrast to the fee-for-service system in which claims to Medicare for QMBs are automatically sent to the state for payment. Payment of these costs means the QMB benefit becomes as valuable to those in HMOs as it is for beneficiaries in traditional fee-for-service Medicare.

❑ ***About a quarter of the states report that they pay the supplemental premiums charged by some Medicare HMOs for Medicare enrollees.*** States are not required, by law, to pay the supplemental premiums so this is an expanded benefit in those states that do pay it.

Program Administration

❑ ***Nearly all states require providers to enter into agreements with the State before they can receive Medicare cost-sharing payments on behalf of QMBs.*** This requirement can result in QMBs being denied access to their regular physician or other provider if that provider is unwilling to participate in the state's Medicaid program.

❑ ***At least one third of the states recover Medicare cost sharing payments from the estates of deceased beneficiaries.*** Even in some states that do not recover such benefits, statements about estate recovery included on the application for benefits may confuse applicants into believing that their estates will be tapped for repayment.

Implications for the Future

Many legislative proposals, both Democratic and Republican, would increase cost-sharing requirements for beneficiaries to keep Medicare fiscally secure in the future. In addition, there continues to be strong interest in encouraging beneficiaries to enroll in Medicare+Choice plans, instead of traditional fee-for-service Medicare. Such significant changes will make easy access to buy-in protections more critical than ever.

States have many possibilities under federal law for improving their buy-in programs. They can increase knowledge of the programs by more coordinated and targeted outreach, using, among other tools, specific beneficiary data available from HCFA. They can ease enrollment difficulties by using simpler forms, by placing more workers in locations where beneficiaries receive health care and related services, by reducing documentation requirements on their applications, and by liberalizing their eligibility rules. They can improve the benefit for all QMBs by paying Medicare co-insurance at the full Medicare rate; they can improve the benefit for those QMBs enrolled in HMOs by establishing systems to identify those individuals and by ensuring that they pay the benefit.

However, many states do not use the tools at hand to make the program most accessible and useful to beneficiaries. HCFA encourages states to improve outreach and simplify enrollment, but exercises no leverage against states that do not act.

The federal government, too, can act to improve the buy-in programs. For example, the Department of Health and Human Services can, through HCFA and through working with the Social Security Administration and other agencies that serve Medicare beneficiaries such as the Railroad Retirement Board (RRB) and the Office of Personnel Management (OPM):

-- identify potential beneficiaries through federal data systems and target outreach to them directly;
-- assist beneficiaries, through the 1,300 local Social Security field offices and the RRB and OPM, in understanding the programs and getting enrolled in them;
-- assess, with an eye toward legislative change, if necessary, the effects on beneficiary access to health care of the Balanced Budget Act amendment allowing states to pay less than full Medicare co-insurance;
-- exercise greater pressure on states to simplify their programs in

accordance with the Medicaid requirement that state programs are to be run in the best interests of recipients, and

-- enforce those provisions of the law that are not optional, such as the requirement that states pay Medicare HMO co-payments.

Because of the wide variations among states in both participation rates and Medicaid policies and practices, policy makers should be mindful of the implications of relying on the existing buy-in system to administer increased cost-sharing requirements proposed in legislation. Moreover, greater attention at the state or federal level is warranted to the needs of buy-in beneficiaries in Medicare managed care plans before pursuing proposals to move more Medicare beneficiaries into managed care and other Medicare+Choice options.

SUMMARY FINDINGS OF PRACTICES IN STATES' MEDICAID BUY-IN PROGRAMS

State	Use of Leads Data	Use of Materials in Other Languages	Use of Out Stationed Eligibility Workers	Use of Mail or Phone Application Without Face to Face Interview	Self-Certification of Income or Resources	Use of Conditional Enrollment for Beneficiaries Without Part A	Use of More Liberal Methodologies for Counting Income or Resources	State Systems for Tracking QMB Medicare HMO Enrollment	No Estate Recovery of Buy-In Benefits	1997 – 1999 Comparisons							
										Full Medicare Reimbursement for QMB Cost-Sharing		Use of Short Form Application		State Payments of Copays in HMOs		Part A Buy-In Agreement	
										1997	1999	1997	1999	1997	1999	1997	1999
AL	X			X		X	X		X	X		X	X	X	X		?
AK				L		X	X	N/A	?	X	X			N/A	N/A	X	X
AR			X			1			X	X	X		X	?	X	X	X
AZ		?		N/A	?	X	?	X	X				X	X			?
CA	X	?		X	L	X		X		?	X		X	?	X		
CO									?					?			
CT		?	?	N/A			X	X		X	?			?	X	X	X
DC	X		?	N/A					?							X	X
DE	X		X		X	X			X	X		X	X	*	X	X	X
FL	?	?		N/A		X	X	X	?	X			?			X	X
GA	X	?	?	N/A			?		X	X			X			X	X
HI			X	L		X	X			X	X			X	X	X	X
IA	X	X	X	L		X				X	X			*		X	X
ID		?		L						X	X			*		X	X
IL	X	X		X	X		X		L			X	X	?			
IN				X		X	X			X	X		X	N/A	X	X	X
KS		?	X	X		X	X										?
KY	?					X		X	X	?		X	X	?	X	?	?
LA	X		X	N/A		X		X	X	X	X					?	
MA				N/A	L	X			?	X			L		?	X	X
MD	X			N/A		?		X		X						X	X
ME				N/A		X	X	*	?	X	X		X	*	*	X	X
MI	?	?	X	N/A				?	X	X				?	X	X	X
MN	X	?	?	N/A	X	X	X			X	X			?	X	X	X
MO	X	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	?	N/A		N/A	*	N/A		

X = Yes
N/A = No Answer
L = Limited Circumstances

? = Not Clear or Unresolved Discrepancy
Blank = No
* = No Medicare Managed Care in the State

1 = Conditional enrollment is not necessary, the state enrolls directly through its buy-in agreement
Total = Sum of X and L

State	Use of Leads Data	Use of Materials in Other Languages	Use of Out Stationed Eligibility Workers	Use of Mail or Phone Application Without Face to Face Interview	Self-Certification of Income or Resources	Use of Conditional Enrollment for Beneficiaries Without Part A	Use of More Liberal Methodologies for Counting Income or Resources	State Systems for Tracking QMB Medicare HMO Enrollment	No Estate Recovery of Buy-In Benefits	1997 – 1999 Comparisons							
										Full Medicare Reimbursement for QMB Cost-Sharing		Use of Short Form Application		State Payments of Copays in HMOs		Part A Buy-In Agreement	
										1997	1999	1997	1999	1997	1999	1997	1999
MS	X			X		X	X	*	X	X		?		*	*	X	X
MT				X		X								*	?	X	X
NC	X		X			X			X	?				?		X	X
ND				X		?	?	*		X	X			*	*	X	X
NE	?	X	X						X	?				?	X		?
NH				N/A		X				X	X	X	X	*	X	X	X
NJ		?	?	N/A	?	X			X	X		X	L	X			
NM	X			N/A		X	X		X	X		X	X	?			
NV		?	X	X		X								?	?	X	X
NY		X	X			X		X		X	X		L	?			
OH	X					X			X	X						?	X
OK	?		?			X			X	?				?	X	X	X
OR		X	X		X	X							X	?			
PA	X	?	?			X			X	X			L	N/A	X	N/A	X
RI				N/A	L	?			X	N/A			L	N/A	X	X	X
SC	X			X		X	X		X	X	X	X	X	?		?	
SD	X			N/A		X	?	*	X	X				*	*	x	x
TN			X	X	?	X			X		L	X	X	X	X	X	X
TX	?	X		L	X	X		X	X	N/A			X	N/A	X	?	X
UT	X		?	X		?		*						?	*	?	
VT	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	X	N/A		N/A	?	N/A	?	X
VA		X	X	N/A		X	?			X				?	X	?	
WA		X	?	X		X			X	X			L	X	X	X	X
WI	?	N/A	X	N/A					?						?	X	X
WV			X	N/A	X	X		?	X			X	X	*	*	X	X
WY	X			X		1		*	X	X	X		X	*	*	X	X
Total	**20**	**8**	**16**	**19**	**9**	**34**	**13**	**9**	**25**	**31**	**16**	**10**	**24**	**6**	**19**	**30**	**34**

INCOME ELIGIBILITY FOR BUY-IN PROGRAMS: 1999

(All programs permit no more than $4,000/individual, $6,000/couple in non-excluded resources)

QMB PROGRAM -- 100% of Poverty

Benefit: Payment of all Medicare cost-sharing

	Monthly Income Threshold*	
	Individual:	Couple:
48 States and the District of Columbia	$707	$ 942
Hawaii	811	1081
Alaska	880	1174

SLMB PROGRAM -- 120% of Poverty

Benefit: Payment of Medicare Part B premium only

48 States and the District of Columbia	$ 844	$1126
Hawaii	969	1293
Alaska	1052	1404

QUALIFIED INDIVIDUAL-1 PROGRAM FOR 1998-2002 – 135% of Poverty

Benefit: Payment of Medicare Part B premium on first-come, first-served basis from a limited pot of money

48 States and the District of Columbia	$ 947	$1265
Hawaii	1088	1453
Alaska	1181	1577

QUALIFIED INDIVIDUAL-2 PROGRAM FOR 1998-2002 - 175% of Poverty

Benefit: Payment of a portion of Medicare Part B premium on first-come, first-served basis from a limited pot of money

48 States and the District of Columbia	$1222	$1633
Hawaii	1404	1877
Alaska	1525	2039

QDWI PROGRAM -- 200% of Poverty

Benefit: Payment of Medicare Part A premium only

48 States and the District of Columbia	$1394	$1864
Hawaii	1602	2142
Alaska	1740	2327

* All numbers are $20 above the relevant poverty threshold due to a $20 unearned income disregard to which all applicants are entitled. Some states disregard additional income and/or exclude greater amounts of resources, thus raising the eligibility ceiling.

INTRODUCTION

Sixteen million Medicare beneficiaries are poor or low-income.[1] These low-income elderly and disabled beneficiaries have greater health care needs and higher health care costs than more affluent Medicare beneficiaries, spending an average of 35% of their income on out-of-pocket health expenses.[2]

In 1988, Congress enacted a program called the Qualified Medicare Beneficiary program to protect poor Medicare beneficiaries from Medicare's out-of-pocket health care costs. Since 1988, Congress has established additional programs to provide more limited assistance to individuals with incomes above the poverty level. [Exhibit A] The programs are generically referred to as buy-in programs, and are operated through state-administered Medicaid programs. Medicaid "buys-into" Medicare on behalf of low-income beneficiaries, paying premiums and in some instances, deductibles and co-insurance amounts. In 1999, assistance is available for various groups of individuals with incomes up to twice the federal poverty level.

Buy-in programs provide critical links to the health care system for low-income Medicare beneficiaries. These individuals are more likely than more affluent beneficiaries to have serious health conditions, are three times more likely to have limitations in activities of daily living, twice as likely to identify themselves as having only fair or poor health and more than four times more likely to have a mental disorder or Alzheimer's disease. They are disproportionately minority, disproportionately women, disproportionately living alone.[3]

Yet an estimated 45% of those eligible for buy-in benefits in the lowest income category (up to 100% of poverty), and even larger shares among those between 100% and 120% of poverty, are not participating.[4] Barriers to program participation have been identified in numerous recent and not-so-recent reports: lack of effective outreach to program beneficiaries; lack of knowledge of the programs on the part of welfare workers, Social Security employees and community based organizations; cumbersome and obstacle-laden enrollment processes that require long waits in welfare offices, face-to-face interviews, and extensive documentation of income and assets, and difficulties with language and transportation.[5]

Participation rates vary significantly across states. A 1998 report by Families USA identifies participation in the lowest income buy-in groups as ranging from 20% in North Dakota to 88% in California.[6] State practices with respect to outreach and enrollment also vary widely. For example, only 20 states use electronic data available to them to identify and enroll potential beneficiaries; 16 states have workers stationed in places other than welfare offices to take applications.[7]

In 1997, the National Senior Citizens Law Center, supported by the Kaiser Family Foundation, reported the results of a survey of State Medicaid directors and advocates to document state practices and policies that would affect beneficiary use of the buy-in programs. Since that time, several developments have occurred.

In the Balanced Budget Act of 1997, Congress amended the buy-in programs in two significant ways. First, it created a limited block grant to states to provide some premium protection to individuals with incomes up to 175% of poverty. It also included language allowing states to pay less than the full Medicare co-insurance rate for the poorest buy-in beneficiaries.

In the past two years, the federal government has increased its focus on buy-in programs [Exhibit C]. The Health Care Financing Administration (HCFA) has identified improved buy-in enrollment as a specific government performance goal and has established a national target of a 4% increase in enrollment by the end of fiscal year 2000. In addition, the Social Security Administration, at the direction of Congress, undertook a 9 month demonstration project in 7 states (later expanded to 12) to test what kind of assistance given at Social Security offices best affects enrollment.

In light of the extreme vulnerability of low-income Medicare beneficiaries, the recent federal legislative and administrative focus on buy-in enrollment and legislative proposals that rely on the existing buy-in system to administer additional cost-sharing protections, the National Senior Citizens Law Center, again supported by the Kaiser Family Foundation, sought to profile state Medicaid program buy-in practices and policies, as a follow-up to the 1997 report.

As in 1997, the Law Center surveyed all State Medicaid Directors and at least one advocate in each state and the District of Columbia. The survey was sent in December 1998 and responses gathered throughout the first half of 1999. Advocates were surveyed both to determine the extent of knowledge in the advocacy community about program practices and to determine any discrepancies between a state's stated policies and perceptions of those policies in the advocacy community. We received responses from 46 state Medicaid officials and 39 advocates. From 36 states, both the state officials and the advocate responded; from an additional 10 states, only the state officials replied and from 3 other states, only the advocate replied. We had no response from 2 states.

HISTORY AND DESCRIPTION OF BUY-IN PROGRAMS

A. HISTORICAL BACKGROUND

The buy-in programs connect the two largest public health care programs in the country: Medicare and Medicaid.

Medicare. Medicare is a fully federal program that provides a standardized package of services to individuals age 65 and older and to certain disabled individuals.

Medicare is divided into two parts, Part A and Part B. Generally speaking, institutional and home health services are paid for through Part A and physician and other "outpatient" services are paid for through Part B. Individuals who receive Social Security, Railroad Retirement or Civil Service Retirement benefits are entitled to Part A services premium-free; the Part B premium, $45.50/month in 2000, is deducted from their monthly check. Others enrolled in Part B are billed by the Social Security Administration; they may also purchase Part A for a premium of $301 per month (2000). Both Part A and Part B require cost-sharing on the part of beneficiaries. Most individuals not enrolled for the buy-in protections described in this report pay their cost-sharing obligations out-of-pocket, or through purchase of a Medi-gap private insurance policy. Eligibility for Medicare is ***not*** based on income or resources.

Exhibit A

LEGISLATIVE HISTORY OF BUY-IN PROGRAMS

1965: (P.L. 89-97) Congress passes Medicare and Medicaid with provision that states can enroll Medicaid recipients in Medicare Part B by paying their Part B premium.

1970: (P.L. 90-248) Congress prohibits federal payments for Medicaid services that could have been paid for by Medicare Part B if the recipient had been enrolled.

1986: (P.L. 99-509) Congress permits states to pay all Medicare cost-sharing (premiums, deductibles, co-insurance) for individuals with incomes up to 100% of poverty who are not otherwise eligible for Medicaid. (QMB option)

1988: (P.L. 100-360) Congress makes the 1986 option a *requirement* for state Medicaid programs, and eliminates the "not otherwise eligible" language. (QMB mandate)

1989: (P.L. 101-239) Congress *requires* states to pay Medicare Part A premiums for certain disabled, working individuals with incomes up to 200% of poverty. (QDWI mandate)

1990: (P.L. 101-508) Congress *requires* states, beginning in 1993, to pay Medicare Part B premium for individuals with incomes up to 110% of poverty; beginning in 1995, the threshold is 120% of poverty. (SLMB mandate)

1997: (P.L. 105-33) Congress provides 100% federal dollars to pay Part B premium, beginning 1998, for individuals with incomes to 135% poverty and a portion of the Part B premium for those with incomes up to 175% of poverty. (Limited funds: capped entitlement). Congress erodes full QMB cost-sharing benefit by allowing states to pay at a rate lower than the full Medicare rate.

Medicaid. Medicaid is a combined federal-state program whose general requirements are dictated by federal law. Medicaid is a means-tested program: eligibility is based on having income and resources below specified ceilings. Medicaid is operated and administered by the states; thus, it is not a single program, but over 50 separate programs with certain similar characteristics. In fact, each state program includes many categories of eligibility; an individual can be eligible under more than one category. The federal government pays between 50% and 83% of all program expenses. Under federal law, states participating in Medicaid must serve certain individuals, including some, but not all, poor aged, blind or disabled individuals, and must provide a specified package of services to those individuals. In addition, states may serve other individuals and provide additional services. Most services provided under Medicaid are provided at the option of the state.[8] However, the buy-in programs are not optional.

B. QUALIFIED MEDICARE BENEFICIARY PROGRAM

The ***Qualified Medicare Beneficiary*** (QMB) program serves individuals with Part A Medicare who have income at or less than 100% of federal poverty guidelines and countable resources of not more than $4,000 for an individual, $6,000 for a couple. This group may include individuals who receive full Medicaid benefits from their state in addition to Medicare cost-sharing, as well as those for whom Medicare cost-sharing is the only benefit they receive.

The benefit for eligible individuals in traditional Medicare fee-for-service is payment of their Part B premium (and Part A premium where necessary)[9], and Part A and Part B deductibles and co-insurance amounts. [Exhibit B] For an individual entitled to QMB benefits who had a short hospitalization followed by 30 days of skilled nursing facility care the benefit would be a minimum of $2392 in out-of-pocket costs for which she would otherwise be responsible.[10] This amount is about 30% of the annual income of a QMB. Although without the QMB benefit, the individual would be responsible for the full $2392, the state will not necessarily pay that much. States need only pay providers up to the Medicaid rate which is often lower than the full Medicare-approved rate. The provider *cannot* charge the QMB the difference, although the provider may decline to serve the individual altogether. Benefits are available in the first month after eligibility has been determined.

EXHIBIT B

WHAT IS THE VALUE OF THE QMB BENEFIT?

FOR 1999, MEDICARE BENEFICIARIES WHO DO NOT HAVE QMB BENEFITS ARE RESPONSIBLE FOR

PART B PREMIUM	$546 PER YEAR
PART B DEDUCTIBLE	$100 PER YEAR
PART A HOSPITAL DEDUCTIBLE	$776 PER BENEFIT PERIOD
PART A HOSPITAL CO-INSURANCE (DAYS 61-90)	$194 PER DAY
PART A HOSPITAL CO-INSURANCE (RESERVE DAYS)	$388 PER DAY
PART A SNF CO-INSURANCE	$97 PER DAY
PHYSICIANS' SERVICES, MEDICAL SUPPLIES, ETC.	20% OF MEDICARE-APPROVED PAYMENT

The QMB benefit can be important even to an individual entitled to full *Medicaid* benefits. This is because QMB payments allow such an individual access to the full range of Medicare services, in addition to whatever the state chooses to provide under its Medicaid program. For example, about 6 states offer no physical therapy and about 15 states offer no occupational therapy in their Medicaid programs;[11] with QMB benefits, low-income Medicare beneficiaries can get these services through Medicare.

C. SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PROGRAM

The ***Specified Low-Income Medicare Beneficiary*** (SLMB) program serves individuals with Medicare Part A who would be QMBs but whose incomes are between 100% and 120% of poverty. SLMBs are entitled to have the state pay their Part B premium only. Unlike QMBS, SLMBs are entitled to three months of retroactive benefits, if they were eligible during those months.

D. QUALIFIED INDIVIDUAL PROGRAM

The ***Qualified Individual*** (QI) program, authorized by the Balanced Budget Act of 1997, provides a five year block grant (1998-2002) to the states to pay premium protection for two groups of Medicare beneficiaries:

a. Individuals who would be QMBs, but whose income is between 120% and 135% of poverty and who are not otherwise eligible for Medicaid, are eligible to apply for payment of the Part B premium by the state. They are called ***QI-1s.***

b. Individuals who would be QMBs, but whose income is between 135% and 175% of poverty and who are not otherwise eligible for Medicaid, are eligible to apply for Medicaid assistance to pay a ***portion*** of their Part B premium. This portion is $2.87 per month in 2000. They are called ***QI-2s.***

Both categories of QI are entitled to up to three month retroactive benefits, if they were eligible during those months. However, unlike QMB, SLMB and QDWI (discussed below), the QI benefit is not an entitlement to any individual; applicants, who must apply each year, are chosen on a first-come, first-served basis and will be given preference in the following year if they received the benefit in the last month of the previous year.

E. QUALIFIED DISABLED AND WORKING INDIVIDUAL PROGRAM

The ***Qualified Disabled and Working Individual*** (QDWI) program serves individuals who are disabled and working in work incentive programs, whose incomes are not more than 200% of federal poverty levels and whose countable resources are not more than $4,000 for an individual and $6,000 for a couple. QDWIs are entitled to have the state pay their Part A premium only. This amount is $309 in 1999. QDWIs are entitled to benefits for up to three months prior to application, if they were eligible during those months.

FEDERAL ACTIVITY

A. THE PRESIDENT'S INITIATIVE

In July 1998 President Clinton announced a new federal initiative, to be undertaken through the Health Care Financing Administration (HCFA) and the Social Security Administration (SSA) to increase enrollment in the buy-in programs. The initiative consisted of nine points, some of which reflected activity already undertaken by the Health Care Financing Administration. Elements of the President's initiative included:

- New efforts to educate Medicare beneficiaries about buy-in programs
- Encouraging states to simplify their application process
- Creating a federal-state-consumer task force to develop new strategies to enroll beneficiaries
- Targeting eligible individuals with direct mailings
- Proving state health insurance counseling programs with materials to assist beneficiaries

Exhibit C

SUMMARY OF RECENT FEDERAL ACTIVITY RELATED TO BUY-IN PROGRAMS

July 1998	President Clinton announced an initiative to increase buy-in participation. The initiative included both previously undertaken and new information distribution activities and the creation of a federal-state-consumer advocate task force to develop new strategies to increase enrollment.
July 9, 1998	The Health Care Financing Administration (HCFA) identified buy-in enrollment as a Government Performance Goal for FY 1999 and following years in a meeting with Consumer Advocates. For FY 1999, its goals are to develop an outreach, enrollment and eligibility simplification strategy and to establish national and state baseline enrollment data and new enrollment targets.
March 1, 1999	The Social Security Administration, under direction from the Congress, began a $6 million, 9 month demonstration project in 7 states to test whether assistance given at Social Security offices helps improve enrollment. In September 1999, SSA added a new component to the demonstration, involving a collaboration with AARP volunteers.

B. HCFA'S GOVERNMENT PERFORMANCE GOAL

Also in 1998, HCFA announced a Government Performance and Review Act (GPRA)goal to increase buy-in enrollment. The specific goals for FY 1999 were to development an "Outreach and Enrollment Simplification Strategy" and to establishment a reliable data baseline of participation at the federal and state levels against which to measure improved enrollment. Some products, to date, of the GPRA activity have been studies of state outreach practices, a report profiling the characteristics of enrolled and eligible-but-not-enrolled beneficiaries, a national conference, regional training events and an Outreach Kit and Resource Guide planned for release before the end of 1999 in both hard copy and electronic form.

C. SSA'S DEMONSTRATION PROJECT

At the direction of Congress, SSA is spending $6 million to test several different methods of providing enrollment assistance through an SSA toll free number and SSA local field offices to see which method is most effective. Four models are being tested through SSA; a fifth model is being tested in collaboration with AARP. Some version of the project is operating in a total of 18 locations spread through 11 states. All models rely on a letter sent on SSA letterhead to individual beneficiaries identified as having low Social Security retirement incomes and thus being potentially eligible for buy-in benefits. The recipients are invited to call a toll free number. In all but the AARP model, they are screened through the toll-free number and, if they appear eligible for benefits, have an interview set up for them. The interview is at 1) their local social services or welfare office (screening model) in three counties in Pennsylvania, 2) their local SSA field office with a state welfare worker conducting the interview (co-location model) in two counties in Pennsylvania and two locations in Oklahoma or 3) their local SSA field office with an SSA worker conducting the interview (application model) in one county each in Kentucky, Indiana and Texas, and in two locations in Florida. A fourth model, implemented throughout the state of Massachusetts, is called the widow(er)s model: when widows or widowers call SSA to report the death of their spouse, they will be screened for potential buy-in eligibility. In the AARP model, in five cities (Los Angeles, California; Omaha, Nebraska; Pittsburgh, Pennsylvania; St. Louis, Missouri and Asheville, North Carolina), the letter will refer the recipient to a toll-free number which in turn will connect the recipient to an AARP volunteer who will screen for eligibility then track the individual's progress through the state welfare system. The demonstration ends at the end of 1999.

D. LEADS DATA

Once a year, HCFA mails "Dear Beneficiary" letters to a targeted sample of newly enrolled Medicare beneficiaries whose Social Security incomes are less than 100% of the federal poverty level, who do not receive Supplemental Security Income and for whom no third party is paying their Medicare premiums.

The data used to generate the sample is referred to as "leads data." HCFA selects its sample from the 32 states that do not receive leads data because they have not asked for it. HCFA does not select from the 19 states that do receive leads data, on the theory that it does not

want to duplicate effort and that those states will conduct their own targeted outreach. However, not all states receiving leads data do use it.

The size of the HCFA mailing depends of funds available. In 1997, for example, HCFA sent letters to 125,000 individuals in the 32 states. The letter informed beneficiaries of the possibility that they could get help paying some or all of their Medicare costs, and set out the income and asset limits. It then directed beneficiaries to call their state Medicaid or social services agency if they wanted to apply. It left to the beneficiary the task of finding the correct telephone number for that agency.

In 1998 and early 1999, HCFA chose a different strategy, in an effort to evaluate the effectiveness of the letter. Rather than mail to a sample in all 32 states, it chose three states, New York, Texas and Michigan, each of which agreed to track responses in order to assist HCFA in its evaluation. HCFA mailed more than 142,000 letters to beneficiaries in the three states: New York (54,130), Texas (60,847) and Michigan (27,902). Those in Texas and New York received a letter, a brochure and a reply card to mail back for additional information. Beneficiaries in Michigan were given a toll free number to call for more information. HCFA is currently evaluating its efforts.

Because leads data only identify poverty-level incomes, include no information on resources and are based only on Social Security income, they are both over-inclusive and under-inclusive to target potential buy-in enrollees. They are over-inclusive because people may have excess resources or additional income that will make them ineligible. They are under-inclusive because they only capture those with incomes up to the poverty level, whereas the buy-in programs providing full Part B premium protection, for which leads data might be most relevant, serve people with incomes up to 135% of poverty. Nonetheless, the data are the most specific information available to date to help identify potential enrollees.

States can receive leads data by contacting HCFA and asking for it.

FINDINGS AND DISCUSSION

Since 1997, many states have simplified and improved their programs in at least two important ways. Use of short form applications has grown from 1/5 of the states (10) in 1997 to ½ (24) in 1999. Simpler applications make it easier for beneficiaries to enroll. Also, in 1999, 19 states (nearly 2/5s) reported paying co-payments for their Qualified Medicare Beneficiaries (QMBs) in health maintenance organizations (HMOs), up from 6 (about 1/8) in 1997. Payment of these costs means the QMB benefit becomes as valuable to those in HMOs as it is for beneficiaries in traditional fee-for-service Medicare.

Also since the 1997 passage of the Balanced Budget Act that authorized states to pay less than full Medicare co-insurance rates, fifteen states have decreased their payment rates. Now, only about a third of the states pay at the higher rate. In 1997, 31 states reported paying co-insurance at the full Medicare rate; in 1999, only 16 states so reported. The Medicare rate is generally higher than the state's Medicaid rate for a similar service; payment at the lower rate can restrict access to providers.

Only about half the states reported undertaking outreach to inform beneficiaries of the Qualified Individual program enacted in the 1997 Balanced Budget Act; few of those states designed special campaigns. According to the Health Care Financing Administration and the Urban Institute, by the end of 1998, the first year of the program, on 1% of the money set aside had been used and only 3% of potential participants had been enrolled.

Perhaps the most significant observation to be made from reviewing state policies and practices with respect to buy-in programs is that, although Medicare is a fully federal program with uniform eligibility requirements, a uniform package of services and a single administrative structure, buy-in benefits for Medicare beneficiaries, administered through State Medicaid programs, have no such uniformity. Although numerous federal courts have relied on the principle that Congress intended "that indigency should not affect an individual's participation" in the Medicare program,[12] in fact, indigency does affect participation since low-income beneficiaries are subjected to the vagaries of state practice despite the buy-in programs' generally uniform eligibility and coverage requirements.

Courts have found that Congress intended " that indigency should not affect an individual's participation" in the Medicare program.

A second overall observation is that parties responding to our survey have conflicting perceptions and understandings of state practices. Survey results identified numerous instances of state Medicaid officials and advocates reporting opposite or at least different answers to the same question. Also, reports of states Medicaid officials sometimes differed with information available from HCFA; at least 7 states reported receiving leads data from HCFA that HCFA denied sending them. Several plausible explanations exist for these disparities. They may reflect the difficulty of identifying the several people within the Medicaid agency who know about

myriad aspects of these complex programs; they may also reflect limited knowledge of the programs on the part of many, though not all, advocates. Finally, where, for example, advocates report they are unfamiliar with state outreach efforts, the disparities no doubt reflect the fact that state efforts are not reaching fully into the communities of those serving the beneficiary population.

States could take numerous steps to eliminate or reduce barriers to participation that result in the programs being underutilized. These steps are discussed in some detail in this section. As the specific findings and discussion demonstrate, all states take some of the steps; no states takes all of them.

The findings are organized under the following headings:, Outreach, Enrollment, Implementation of Qualified Individual Program, Eligibility, QMB Cost-Sharing Benefit, Medicare Managed Care Enrollment and Program Administration.

A. OUTREACH

How do states identify potential beneficiaries and how do they get information to them? A range of possibilities is available to states to increase public awareness of programs. States can produce a variety of materials, engage in targeted mailings to identified low-income individuals, and produce materials in foreign languages spoken by their residents.

❑ ***FINDING: Few states undertake aggressive or targeted outreach, relying primarily on brochures and fliers to inform the public about their programs.***

New Jersey builds on the popularity of its Pharmaceutical Assistance for the Aged and Disabled (PAAD) program to identify those potentially eligible for the QMB, SLMB and QI programs. The state reviews eligibility information for PAAD and sends a cover letter and partially completed application to likely beneficiaries, instructing them to complete the form and return it if they are interested in benefits. The state believes this has been highly effective, as the PAAD program enrollment requirements are more user friendly than Medicaid's.

Most states use only one or two types of outreach, with about two-thirds of the states using mostly brochures or fliers in county welfare offices, provider offices and senior centers. Only about five states use posters in public places or electronic media public service announcements. New York has, at least once, included program information in utility bills. New Jersey screens all participants in its popular prescription drug program for possible buy-in eligibility. To those who appear eligible, the state sends an explanatory cover letter and a short application form, partially completed based on information provided for the drug program. The state asks the individual to complete the remaining questions on the form and return it if interested in a buy-in program.

❑ ***FINDING: About a dozen states report having outreach materials concerning the buy-in programs in languages other than English; only four reported having materials in additional languages other than Spanish.***

Many people concerned with low enrollment consider the lack of availability of program information in other languages to be a barrier to participation,[13] yet few states have materials in languages other than English. Among those that do, some report only applications and related notices are printed in other languages, *not* informational brochures and fliers.

Washington State provides a QMB brochure and a QI application in seven languages: Spanish, Russian, Vietnamese, Cambodian, Chinese, Korean and Laotian.

A report prepared for the Health Care Financing Administration identified low-income Hispanic Americans as among those most under-represented in the program;[14] about 22 states reported having some materials (applications or brochures) in Spanish.

Oregon and Washington State report having materials in seven languages. Washington, for example, provides a QMB brochure and a QI application in: Spanish, Russian, Vietnamese, Cambodian, Chinese, Korean and Laotian. Minnesota reports having materials in six languages. However, advocates in Minnesota assert that materials specific to buy-in programs are *not* translated to other languages and that the application form has a brief notice on it in many languages offering the applicant translator services, if necessary.[15] To have such a notice on the application is irrelevant to an individual who has no knowledge of the program in the first place.

Although California reported having no materials in other languages, in a separate report, California is described as responding to ethnic and language issues by recruiting outreach workers from ethnic communities who speak the language of those who are potentially eligible.[16]

❑ ***FINDING: Between a third and half the states place their own eligibility workers in settings other than welfare offices to certify eligibility for buy-in programs; however, this is often only a few workers and only at a few locations. At least 11 states require face-to-face interviews at whatever location the application is taken.***

Enrollment can be made easier by locating eligibility workers in settings where potential beneficiaries are receiving medical care, meals or other services. This practice is called out-stationing. Federal law requires the out-stationing of workers at certain hospitals and health centers to enroll certain categories of Medicaid recipients, but older people and people with disabilities – those eligible for buy-in benefits-- are not among those for whom out-stationing is mandatory. The states that do out-station workers generally do so at a few hospitals; some also do it at community health centers. Kansas, Minnesota and New York reported out stationing workers in senior centers, in addition to hospitals and health centers. Respondents were not always clear as to whether their out-stationed workers were directed to take buy-in applications as well as other Medicaid applications. If the state requires a face-to-face interview, as at least 11 states do, completing the interview at the out-station location relieves the applicant of making a separate trip to a welfare office.[17]

❑ ***FINDING: Only about a third of the states report making eligibility screening tools available to outside agencies; about half permit others than their own eligibility workers to accept completed applications and forward them to the state.***

A theme in the literature analyzing enrollment barriers and successful ways to overcome them is the importance of providing individualized assistance to potential beneficiaries. Community-based organizations that routinely have contact with low-income older people can screen for eligibility and assist with completion of applications.[18] Such activities can take place at nutrition sites, providers' offices, senior centers, food distribution centers, public housing authorities, churches and other convenient locations if screening tools and applications are available.

In Tennessee, outreach activities are contracted out to a legal services organization which has created a "Medical Bills Blues" flier. The flier, which is sent to the state and to 200 organizations, can be used as a screening tool. Tennessee uses a one-page application form, easily usable by other organizations assisting beneficiaries, that requires only a name, address and signature to establish a date of eligibility for various assistance programs. An eligibility worker from the state subsequently gathers additional needed information during an interview with the applicant. Nearly all states reported that the effective date of an application is the date it is received in the eligibility office, not necessarily the date it is completed, if completed elsewhere. Community-based organizations completing applications for beneficiaries need to be attentive to forwarding the completed applications immediately.

In Tennessee, outreach activities are contracted out to a legal services organization which has created a "Medical Bills Blues" flier. The flier, which is sent to the state and to 200 organizations, can be used as a screening tool. Tennessee uses a one-page application form, easily usable by other organizations assisting beneficiaries, that requires only a name, address and signature to establish a date of eligibility for various assistance programs. An eligibility worker from the state subsequently gathers additional needed information during an interview with the applicant.

B. ENROLLMENT

How easy is it for beneficiaries to act on the information they have? A range of possibilities is available to states to ease the process of enrolling in programs once individuals learn about them. States can rely on data available electronically from the federal government or from other state agencies to enroll individuals directly without requiring an application and to target outreach efforts. They can place their own eligibility certification workers in settings where beneficiaries are seeking health services. They can shorten their application forms and simplify their application process by eliminating the requirement for face-to-face interviews, by allowing applicants to self-certify as to the truth of the contents of the application and by ensuring that their eligibility workers or their computerized eligibility determination programs screen applicants for eligibility for any Medicaid program to which they might be entitled. Some states do each of these things; no state does all of them.

❑ ***FINDING: Only 20 states receive data available monthly from the Health Care Financing Administration that identify low-income individuals newly enrolled in Medicare.***

Since about 1995, HCFA has made available to the states, on request, monthly data identifying by name and address newly enrolled Medicare beneficiaries whose Social Security income is at or below 100% of federal poverty levels.[19] This data, called leads data, can be used for direct mailings to potential beneficiaries, for cross-checking against existing Medicaid rolls to directly enroll individuals in the QMB program and for other targeted outreach and enrollment activities. Georgia, for example, reports using the data both to reach out directly to the individuals as well as to alert its eligibility staff to potential enrollees.

Although HCFA informs all states about the availability of this data, according to HCFA, only 20 states receive it. (Some states reported receiving the data, but do not appear on HCFA's list of those receiving it. This discrepancy suggests that states may be confused as to exactly what the data is.) HCFA conducts limited outreach to a sample of beneficiaries in those states that do not receive the data. HCFA does not select its sample from among the states that do receive leads data, on the theory that it does not want to duplicate effort. However, only about 12 of the 20 states use the data for direct outreach.[20]

❑ ***FINDING: About two-thirds of states use information already in their possession to certify and enroll potential beneficiaries in the QMB program; only about one-third rely on electronic data exchange systems with the federal government to facilitate enrollment.***

The daunting aspects of the application process – requirements for face-to-face interviews often necessitating long waits in welfare offices, lengthy application forms, demands for documented verification of all information on the application – suggest that states should facilitate enrollment wherever possible by relying on existing data within their own systems or data available from the federal government through data exchange systems.

For example, states could identify through their existing Medicaid rolls current Medicare beneficiaries with incomes at or below 100% of poverty and automatically enroll them as QMBs. Yet a third of the states do not do this routinely and more than a third do not do it for all such beneficiaries. In these states, a poor individual already receiving full Medicaid must apply separately for QMB status. QMB status is beneficial even to such individuals, since not all Medicaid programs provide as extensive hospital, rehabilitative and therapy coverage as Medicare does.[21]

Using leads data, discussed above, states can cross-check new Medicare enrollees against existing Medicaid rolls to identify new QMBs or SLMBs.

Moreover, when an individual loses full Medicaid eligibility, states could automatically redetermine their eligibility for QMB or SLMB benefits using existing income and resource information. Although states are required by law to do this,[22] not all do.[23]

❑ ***FINDING: Although HCFA has urged states to do so, only about half of the states use a short form application to determine eligibility for buy-in programs. This is an increase from only one-fifth in 1997.***

Complexity of the application process has been identified as a barrier to program participation, and the length of the application form itself contributes to that complexity.[24] Because the application for full Medicaid benefits ranges from 6 to 24 pages long, advocates have promoted the use of shorter forms for the more limited buy-in programs. States justify their use of long forms by pointing out that they allow eligibility workers to screen an applicant for all Medicaid categories for which she might be eligible; in some cases, states actually screen for eligibility for multiple public benefits with the same application. Nonetheless, the application can be daunting and considered to be not worth the time for someone who expects less than full Medicaid coverage. As long ago as 1993, Secretary of HHS, Donna Shalala directed the creation of a prototype short form application which was sent to the states. But six years later, still only 24 states (up from 10 in 1997)[25] use a shorter form, and some of those are not used for all buy-in programs. HCFA again, in early 1998, urged the states to adopt simplified procedures, including the use of a shorter form.

❑ ***FINDING: Only a few states allow applicants for buy-in benefits to self-certify as to the truth of information contained in their application.***

Complexity in enrollment is increased by onerous verification requirements –applicants generally must document date of birth, residence, all sources of income and resources and other information included in the application. One way to ease the burden of applying for benefits is to allow applicants to attest to the truth of the contents of their application. However, states are fearful of making erroneous determinations of eligibility for which they could (but are not likely to) be penalized by HCFA under quality control requirements.[26] They defend their cumbersome verification requirements by saying that verification protects "the integrity of the program,"[27] or that they don't want to have to terminate benefits to someone enrolled erroneously. However, states that have dropped some verification requirements in other portions of their Medicaid programs report no increase in their error rates.[28] Between 6 and 10 states reported on the buy-in survey that they allow self-certification of some or all application information.

As part of a larger effort to encourage states to simplify their application and enrollment processes, HCFA has reminded states of the availability of quality control pilot programs that will allow them to measure the impact of reducing enrollment obstacles without strict observance of current eligibility quality control requirements.[29]

❑ ***FINDING: While nearly all states report that they screen all Medicaid applicants for eligibility for buy-in programs, advocates say otherwise.***

Because each state's Medicaid program has many paths to eligibility, it is difficult, if not impossible, for an applicant to identify with precision what she is applying for. She is unlikely to ask explicitly to be considered for full Medicaid, for QMB, for SLMB and for QI. She should, nonetheless, be able to rely on the state to consider her eligibility for any program for which she qualifies. If, for example, she is found to have too much income to be eligible for the full package of Medicaid benefits, her income might nevertheless be low enough to qualify for a buy-in program, and she should be considered for each one. However, if eligibility

determination systems are not fully coordinated to assure such a result, applicants may be erroneously denied benefits. Florida, for example, reports that its computerized system was designed before the SLMB program became effective, requiring a manual determination of SLMB eligibility. If the applicant does not explicitly request SLMB benefits, which she is unlikely to do because the programs are not well known, the system may not screen for her eligibility. Advocates in other states report similar issues.

❑ FINDING: At least seventeen states do not have agreements with the federal government that allow them to enroll certain individuals as QMBs throughout the entire year.

To be eligible for QMB benefits, individuals must have Medicare Part A. Most Medicare beneficiaries receive Part A automatically, without paying a premium, as a result of their contributions to the Social Security system. People with insufficient Social Security earnings, however, are not entitled to premium-free Part A;[30] the monthly cost, should they choose to purchase Part A, is $309 in 1999. This amount is 45% of the income of an individual living in poverty and eligible for QMB benefits; Part A is thus clearly unaffordable to such a person.

Under an agreement with the federal government, called a Part A buy-in agreement, state Medicaid programs can enroll these individuals in Part A and make them eligible for QMB benefits. Otherwise, the individuals must follow a complex multi-step process that can only be accomplished during the initial Medicare enrollment period or the general enrollment period from January through March each year, with benefits starting July 1.[31] Seventeen states do not have Part A buy-in agreements. This means that individuals without Part A in those seventeen states are denied QMB benefits for as many as fourteen months if they miss the general enrollment process.[32] States justify their lack of a Part A buy-in agreement on the grounds of cost-effectiveness, but in fact, they must enroll those who go through the enrollment process anyway. The implication of their policy is that they assume few will ask about or pursue conditional enrollment. The clearest effect of not having a Part A agreement is to limit eligibility for QMB benefits for some beneficiaries who are among the poorest.

C. QUALIFIED INDIVIDUAL PROGRAM IMPLEMENTATION

Congress created the Qualified Individual program in the Balanced Budget Act of 1997, effective January 1, 1998. Unlike other buy-in programs, the QI program is operated as a block grant to the states. An allocation of federal money is made to each state each year to pay all or a portion of Part B premiums; the state is not required to match the federal money. At the end of the year, unused money reverts to the federal Treasury and is thus forever lost to the state. Despite this incentive to states to get the program up and running quickly, implementation was slow. According to HCFA and Urban Institute estimates, by the end of 1998, only one percent of the $200,000,000 set aside for the program for that year had been spent and only 16,000 of an estimated 500,000 potential participants had been enrolled.[33]

❑ ***FINDING: Only about half the states reported undertaking outreach efforts to inform individuals of the new QI program, and few of those states designed special campaigns.***

Most of the 29 states that reported doing any outreach at all for the QI program described primarily updating existing buy-in program literature to include QI information, rather than using the advent of a new program as a vehicle for focusing attention on all the Medicare assistance programs. A few did report working with community groups not only to distribute materials, but also to develop strategies and materials. At least one state, Arizona, sent letters to all those who had recently been denied QMB or SLMB benefits, inviting them to enroll in the new program for people with higher incomes. South Carolina invented "Blitz Week" for the third week in May 1998 to focus on the QI-1 population, those with incomes up to 135% of poverty. Blitz week involved stationing I-CARE volunteers and, wherever possible, Department of Social Services (DSS) eligibility workers, at Council on Aging offices in each county to assist individuals in completing applications. Completed applications were to be forwarded to the County DSS office for processing.

South Carolina invented "Blitz Week" for the third week in May 1998 to focus on the QI-1 population, those with incomes up to 135% of poverty. Blitz week involved stationing I-CARE volunteers and, wherever possible, Department of Social Services (DSS) eligibility workers, at Council on Aging offices in each county to assist individuals in completing applications. Completed applications were to be forwarded to the County DSS office for processing.

❑ ***FINDING: Most states are making the required annual re-enrollment in the Qualified Individual program relatively easy by mailing applications or re-certification forms to current recipients for them to return.***

States were asked what would be required of those certified as Qualified Individuals in one year to receive benefits for the following year. The statute requires renewed annual enrollment, with preference given to those who received benefits in the previous year. This is significant because of the block grant nature of the program: the total appropriation for 1998 allowed for about 500,000 individuals to be served out of a potential universe of over 1.6 million.[34] Connecticut, Florida and Utah all report that they will automatically re-enroll or re-certify individuals; Utah makes it clear that nothing is required of the individual unless evidence exists that she or he is no longer eligible.

D. ELIGIBILITY

States can encourage and facilitate enrollment in buy-in programs through the design of their eligibility rules and by choosing an option to provide full Medicaid benefits to individuals with incomes at or below 100% of federal poverty guidelines.

❑ ***FINDING: Between a quarter and a third of the states use methods of determining eligibility that are more generous than those used by the SSI program and by the remaining states; 12 states provide full Medicaid coverage to poor older people and people with disabilities.***

Although the buy-in programs generally use SSI rules to determine how to count income and resources, states are allowed to adopt eligibility rules that are more generous than SSI's rules. More generous methods include disregarding additional amounts of income or some or all resources in the eligibility process. Alabama, for example, has eliminated the resource test altogether, thereby simplifying the application process. An applicant for buy-in benefits in Alabama is spared the onerous task of verifying the value of such items as cars, bank accounts, life insurance and burial funds.[35] While not every more generous rule results in an easing of the enrollment process, all do expand eligibility for the program by allowing for the inclusion of individuals with slightly more income or resources than would otherwise be allowed.

Alabama has eliminated the resource test altogether, thereby simplifying the application process. An applicant for buy-in benefits in Alabama is spared the onerous task of verifying the value of such items as cars, bank accounts, life insurance and burial funds.

In addition, twelve states have chosen a Medicaid option that allows full Medicaid coverage for aged, blind and disabled individuals with incomes up to 100% of the poverty level.[36] This means that individuals who would, in other states, be eligible only for Medicare cost-sharing as a QMB, are eligible for both QMB and full Medicaid benefits. In seven of those twelve states, enrollment rates for the buy-in programs appear to be higher than the national average, suggesting that access to a fuller set of benefits may provide greater incentive to enroll.

❑ ***FINDING: Less than half of the states use an income standard for families that recognizes the full size of the family.***

Although the law directs states to use an income standard for the size of the family involved,[37] most states rely on SSI methodology which only recognizes a two person family. In a family where the applicant is the sole breadwinner for four other people, it creates extreme hardship to measure his or her income against a standard for two people, rather than the more appropriate standard for five. While most states make some allowance in their eligibility determination for other family members, the allowance is not necessarily the dollar equivalent of measuring against a higher standard.

E. QMB COST-SHARING BENEFIT

The QMB benefit is the most expansive of the buy-in benefits; in addition to paying premiums, the benefit also covers deductibles and co-insurance amounts that Medicare beneficiaries are otherwise required to pay. However, although QMB beneficiaries are excused from paying the additional costs, states are not required to pay co-insurance to providers at the full Medicare rate. Beneficiaries' access to services may be adversely affected by the level of reimbursement made by the state to providers of services.

❑ ***FINDING: Less than a third of the states reimburse providers serving QMBs at the full Medicare rate, rather than at the generally lower state Medicaid rate. In 1997, nearly two-thirds of states paid at the higher rate.***

Exhibit D

QMBS ARE DENIED FULL ACCESS TO MEDICARE PROVIDERS

Two state practices result in limiting access of Qualified Medicare Beneficiaries to fewer providers than are available to more affluent Medicare beneficiaries. First, most states pay providers only at the Medicaid rate, even if the Medicare rate is higher. Second, virtually all states require providers to apply to the state and enter into provider agreements before they can receive any reimbursement for a QMB. Both of these practices limit the choices of QMBs to a provider pool that is generally smaller than that participating in Medicare.

Prior to passage of the Balanced Budget Act of 1997, at least four federal Circuit Courts of Appeal had found that federal law requires states to reimburse Medicare co-payments to those who provide services to QMBs at the full Medicare rate.[38] This means that if Medicare approves a physician's charge of $100 for a visit, Medicare pays $80 (80%) and the state is obligated to pay $20 (the 20% that is otherwise the beneficiary's responsibility). Despite these court findings, in 1997 between 12 and 20 states paid only up to the Medicaid rate.[39] In the above example, if the Medicaid rate for the physician's charge were $70, the state would pay nothing. Providers' representatives declared in litigation that states' lower Medicaid reimbursement rate resulted in providers dropping out of the program or serving only a limited number of QMBs.[40] In fact, by limiting payment to the Medicaid rate, if lower, states limit access for QMBs to only those providers willing to accept that rate, putting QMBs at a disadvantage compared to more affluent Medicare beneficiaries.

In 1997, in the Balanced Budget Act, Congress explicitly permitted states to pay at the lower rate, but also made it clear that providers could not charge beneficiaries any balance.[41] Since passage of the Act, the number of states paying at the lower rate has increased to 36. If providers decline to serve QMBs, rather than agree to forego the 20% Medicare copayment, these beneficiaries will lose access to doctors and other providers who serve those at higher income levels. [Exhibit D]

F. MEDICARE MANAGED CARE ENROLLMENT

Managed care enrollment for the entire Medicare population is expected to nearly double between 1998 and 2009; enrollment projections identify an increase from 16% to 31% of beneficiaries.[42] While the low-income population has tended to be under represented in the managed care component of Medicare, nevertheless, nearly 300,000 of those eligible for both Medicare and some form of Medicaid are enrolled in Medicare managed care.[43]

Managed care can be beneficial to low-income Medicare beneficiaries who are not entitled to full Medicaid because they can get prescription drug coverage not otherwise available through Medicare. As Medicare +Choice options become more widely available, beneficiaries will have many alternatives to traditional fee for service Medicare. States are required by law to pay co-pays of QMBs enrolled in Medicare managed care, just as they are required to pay cost-sharing in traditional (fee for service) Medicare.[44] States are not, however, required to pay additional premiums that managed care plans may charge in addition to the Part B premium.

❑ ***FINDING: Only about a fifth of the states that have Medicare managed care plans have systems for identifying QMBs who are enrolled in them.***

States cannot systematically pay Medicare co-pays for those enrolled in managed care if they do not know who they are. While fee-for-service Medicare providers generate claims which are sent on to the states after Medicare has paid its portion, managed care health maintenance organizations (HMOs), which receive a monthly capitated rate for each person enrolled, do not. They generally collect co-payments directly from the consumer at the time of service. Thus, without knowing who is in managed care, the state is not in a position to arrange for the HMO to bill it rather then the consumer. Since Medicaid generally does not reimburse consumers, the QMB in an HMO stands to incur nonreimbursable out of pocket expenses that she should not have had to pay.

Although many states report having no system that allows them to know which QMBs are enrolled in Medicare HMOs, states that do have a system receive data from HCFA through a tape data exchange. Other states, then, are either unaware of the availability of this data, or are disinclined to avail themselves of it. Without the specific data, states are left with somewhat random methods of identifying Medicare HMO-enrolled QMBs, such as relying on the provider submitting a claim, or on the beneficiary informing them. This may never happen if the beneficiary does not realize it is her obligation to inform the Medicaid agency or if she thinks it is her own responsibility to pay the co-payment requested by the HMO.

❑ ***FINDING: Less than half of the states that have Medicare managed care plans pay co-payments for QMBs who are enrolled in Medicare HMOs; only about a quarter of the states pay premiums.***

HCFA advises states that they must pay *co-payments* for QMBs in Medicare HMOs but they are not required to pay *premiums* that HMOs sometimes charge that are in addition to the Part B premium that Medicare charges all Part B enrollees.[45] Yet since many states cannot identify those QMBs who are enrolled in HMOs, it is virtually impossible for them to pay even the co-payments on a systematic basis. Some of those states reporting that they pay only do so when a claim is submitted to them by the provider or the beneficiary. This failure of the state to pay required co-payments deprives beneficiaries of cash that they could use to pay for other essential needs or it can threaten their participation in their HMO, if they do not pay the co-payments, since a plan can unilaterally disenroll a participant who does not pay cost-sharing obligations.[46]

G. PROGRAM ADMINISTRATION

States can create or reduce barriers to program participation by the intended beneficiaries by choices they make in the administration of their program. Two such examples are the process they require for a provider to submit a Medicaid claim to the state and whether they require recovery of buy-in benefits from the estate of a deceased beneficiary.

❑ ***FINDING: Nearly all states require providers to enter into agreements with the state before they can receive Medicare cost-sharing payments on behalf of QMBs.***

Federal law requires states to have agreements concerning record keeping and required disclosures of information with every person or institution providing services under the state's Medicaid plan.[47] Virtually all states extend this requirement to Medicare providers to whom they are paying only the co-payment, if any, under the QMB program. Generally they require the provider to complete an application between one and twenty-eight pages long and to be assigned a Medicaid number prior to making a claim for services rendered. Because of these requirements, Medicare providers who do not wish to participate in the Medicaid program cannot serve QMBs and be reimbursed. Like the provider reimbursement rate discussed earlier in this report, this practice on the part of the states limits the choice of providers available to QMBs to those willing to participate in Medicaid and receive Medicaid rates of reimbursement. [Exhibit D]. Only Utah and Virginia reported that their Medicaid provider certification process is either abbreviated (Virginia) or by-passed altogether (Utah) for Medicare providers submitting claims for QMB-only beneficiaries.

❑ ***FINDING: At least one third of the states recover Medicare cost sharing payments from the estates of deceased beneficiaries.***

Fear of estate recovery has been identified as a barrier to program participation.[48] Although states are not required to recover Medicare cost-sharing benefits from the estates of deceased beneficiaries, except from certain nursing facility residents, they are authorized by federal law to do so if they choose.[49] Even in those states that do not recover Medicare cost-sharing, applicants for benefits may believe that applying for benefits will result in the state taking whatever little money they have in the bank when they die. Some states, for example, use a single application for all kinds of Medicaid. Included in the application is an explanation of estate recovery, explaining that the state only recovers funds for services required by the federal regulations. This information may be confusing to an applicant and cause her to decline benefits.

CONCLUSION

Buy-in is a simple concept: Medicaid pays Medicare's premiums, and for QMBs, other cost-sharing, as well, to allow low-income beneficiaries to participate fully in the Medicare program. Congress has repeatedly relied on Medicaid buy-in programs to provide these protections; it is likely it will continue to do so in the future. Such protections can mean the difference between having a regular source of care or not, between delaying needed care due to unaffordable cost or not.

But gaining access to these mandated protections is not easy. Policies and practices vary dramatically from state to state. Unlike Medicare, Medicaid is not a single program; it is fifty-one different programs, in each of the fifty states and the District of Columbia. Even within a state, policies and practices may differ among categories of Medicaid coverage so that, for example, the process for applying for SLMB benefits is different from the process for applying for QMB benefits. Moreover, states demonstrate increasing unwillingness to pay QMB cost-sharing at the full Medicare rate and continued reluctance to develop systems to track QMBs enrolled in Medicare managed care.

Many legislative proposals, both Democratic and Republican, would increase cost-sharing requirements for beneficiaries to keep Medicare fiscally secure in the future. In addition, there continues to be strong interest in encouraging beneficiaries to enroll in Medicare+Choice plans, instead of traditional fee-for-service Medicare. Such significant changes will make easy access to buy-in protections more critical than ever.

States have many choices under federal law in operating their buy-in programs. They can increase knowledge of the programs by more coordinated and targeted outreach, using, among other tools, specific beneficiary data available from HCFA. They can ease enrollment difficulties by using simpler forms, by placing more workers in locations where beneficiaries receive health care and related services, by reducing documentation requirements on their applications, and by liberalizing their eligibility rules. They can improve the benefit for all QMBs by paying Medicare co-insurance at the full Medicare rate; they can improve the benefit for those QMBs enrolled in HMOs by establishing systems to identify those individuals and by ensuring that they pay the benefit. But States do not always choose policies that make the program most accessible and useful to beneficiaries. HCFA encourages states to improve outreach and simplify enrollment, but exercises no leverage against states that do not act.

The federal government, too, can act to improve the buy-in programs. For example, the Department of Health and Human Services can, through HCFA and through working with the Social Security Administration and other agencies that serve Medicare beneficiaries such as the Railroad Retirement Board (RRB) and the Office of Personnel Management (OPM)

-- identify all potential beneficiaries through federal data systems and target outreach to them directly;
-- assist beneficiaries, through the 1,300 local Social Security field offices and through the RRB and OPM, in understanding the programs and getting enrolled in them;
-- undertake, with an eye toward legislative change, if necessary, an investigation of the effects on beneficiary access to health care of the Balanced Budget Act amendment allowing states to pay less than full Medicare co-insurance;
-- exercise greater pressure on states to simplify their programs in accordance with the Medicaid requirement that state programs are to be run in the best interests of recipients, and
-- enforce those provisions of the law that are not optional, such as the requirement that states pay Medicare HMO co-payments.

Because of the wide variations among states in both participation rates and Medicaid policies and practices, policy makers should be mindful of the implications of relying on the existing buy-in system to administer increased cost-sharing requirements proposed in legislation. Moreover, greater attention at the state or federal level is warranted to the needs of buy-in beneficiaries in Medicare managed care plans before pursuing proposals to move more Medicare beneficiaries into managed care and other Medicare+Choice options.

ENDNOTES

1. Kaiser Commission on Medicaid and the Uninsured, Key Facts: "Medicare and Medicaid for the Elderly and Disabled Poor," The Henry J. Kaiser Family Foundation, May 1999 [hereafter Kaiser Key Facts]

2. *Id.*

3. This information is taken from " A Profile of Dually Eligible Beneficiaries, " data compiled by the Health Care Financing Administration , March 1997 from three sources: HCFA Form 64, a report submitted by State Medicaid programs to HCFA; Medicare Current Beneficiary Survey, data gathered from interviews with a sample of Medicare beneficiaries and from Medicare claims files; and Massachusetts Medicare and Medicaid Data, a file that links 3 years of Medicaid data for all senior and persons with disabilities to Medicare data for those same individuals.

4. Barents Group LLC. "A Profile of QMB-Eligible and SLMB-Eligible Medicare Beneficiaries," Contract #500-95-0057/Task Order 2, prepared for the Health Care Financing Administration, April 7, 1999 [hereafter Barents].

5. General Accounting Office. *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment.* GAO/HEHS-99-61, (April 1999) [hereafter "GAO-99"]; AARP Public Policy Institute. *Bridging the Gaps Between Medicare and Medicaid: The Case of QMBs and SLMBs.* Washington, D.C., AARP, (January 1999) ["AARP"]; Families USA. *Shortchanged: Billions Withheld from Medicare Beneficiaries.* Washington, D.C., Families USA, (1998)[hereafter "Shortchanged"]; Nemore, Patricia B. *Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries.* Washington, D.C. ,The Henry J. Kaiser Family Foundation, (November 1997)[hereafter "Variations"]; Neumann, Peter J., Mimi D. Bernardin, Ellen J. Bayer, and William N. Evans. *Identifying Barriers to Elderly Participation in the Qualified Medicare Beneficiary Program.* Final Report submitted to Health Care Financing Administration, 1994; General Accounting Office. *Medicare and Medicaid -- Many Eligible People Not Enrolled in Qualified Medicare Beneficiary Program.* GAO/HEHS-94-52, (January 1994)[hereafter "GAO-94"]; Families USA. *The Medicare Buy-In: A Promise Unfulfilled.* Washington, D.C., Families USA, (March 1993)[hereafter "Promise"]; Families USA. *The Medicare Buy-In: Still A Government Secret.* Washington, D.C., Families USA, (March 1992); Families USA. *The Secret Benefit – The Failure to Provide the Medicare Buy-In to Poor Seniors.* Washington, D.C., Families USA, (1991).

6. "Shortchanged," *supra* note 5, Table 1.

7. See Findings and Discussion, *infra,* at 13-15.

8. Medicaid includes seven mandatory services and seventeen optional services. 42 U.S.C. § 1396a(a)(10)(A) and § 1396d.

9. Most Medicare beneficiaries are entitled to Part A premium-free; their only cost-sharing obligations are for deductibles and co-insurance. However, some individuals do not have sufficient earnings credits in the Social Security system to be entitled to Part A automatically. These individuals are eligible to purchase Part A, for a monthly premium, if they are enrolled in Part B.

10. The $2392 is arrived at by adding $546 ($45.50 per month) for the Part B premium, plus $100 for the Part B annual deductible, plus $776 Part A deductible for each hospitalization benefit period, plus $97 per day (or $970 total) for the 21st through 30th day of skilled nursing facility care.

11. "Medicaid Services State by State," HCFA Pub. No. 02155-97, October 1, 1996.

12. *Rehabilitation Association of Virginia v. Kozlowski*, 42 F. 3d 1444, 1459 (4th Cir. 1994). *See also New York City Health and Hospitals v. Perales*, 954 F. 2d 854 (2d Cir. 1992).

13. *See, e.g.,* Barents, *supra* note 4 and "GAO-99," *supra* note 5.

14. Barents, *supra* note 4, at x.

15. Information from survey completed by Greg Marta, Southern Minnesota Regional Legal Services, Inc. and from telephone conversation between Patricia Nemore, National Senior Citizens Law Center and Barbara Collins, Legal Services Advocacy Project, St. Paul, Minnesota, July 16, 1999.

16. "AARP," *supra* note 5 at 10.

17. At least 3 states – Colorado, Kentucky and Ohio – report having no out-stationed workers and requiring face-to-face interviews. This means that individuals applying for benefits must do so in person at a local welfare or social services office, often necessitating lengthy waits in uncomfortable settings.

18. *See, e.g.,* "GAO-99," "AARP," "Promise," *supra* note 5.

19. This data is provided in response to a 1994 law that states "Not later than 1 year after the date of the enactment of this Act [October 31, 1994], the Secretary of Health and Human Services shall establish and implement a method for obtaining information from newly eligible Medicare beneficiaries that may be used to determine whether such beneficiaries may be eligible for medical assistance for Medicare cost-sharing under State Medicaid plans as qualified Medicare beneficiaries, and for transmitting such information to the State in which such a beneficiary resides." Pub. L. 103-432, Title I, § 154. HCFA has never actually done what the law directs; it has, instead, provided leads data on request.

20. American Public Human Services Association. "Dual Eligible Outreach and Enrollment: A View from the States." prepared under contract for the Health Care Financing Administration. (March 1999)

21. Legally, rehabilitative services under Medicare and Medicaid are identical: the Medicaid definition cross-references to Medicare. See 42 C.F.R. § 440.40 referencing 42 C.F.R. §§ 409.31 through 409.35. However, for years advocates have expressed the view that it is more difficult to get rehabilitative services under Medicaid in a nursing facility than it is under Medicare. Moreover, at least 11 states provide limited or no therapies in their Medicaid program: AL, AK, CO, DE, FL, LA, MO, OK, PA, RI, TN. Source: HCFA Pub. No. 02155-97, Medicaid Services State by State, October 1, 1996.

22. 42 C.F.R. § 435.916 requires states to "promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his eligibility." This regulation has been interpreted by courts and by HCFA to require states to conduct ex parte redeterminations, using data available to them, before requiring additional information from the beneficiary. *Massachusetts Association of Older Americans v. Sharp*, 700 F.2d 749 (1st Cir. 1983). States must also continue benefits until they have completed such an ex parte redetermination. *Crippen v. Kheder,* 741 F.2d 106, 107 (6th Cir. 1984)

23. *See, e.g.* AARP, *supra* note 5, at 17.

24. *See, e.g.,* "GAO-99," "AARP," "Variations," "GAO-94," "Promise," *supra* note 5.

25. "Variations," *supra* note 5, at vi-vii.

26. States are required to review both active cases (open beneficiary files) and "negative case actions" (denials or terminations of eligibility) to determine errors, but they are penalized, by the disallowance of federal funds, only for improper determinations of eligibility, not for improper denials or terminations. 42 C.F.R. § 431.800 et seq.

27. *See, e.g.,* response from Nebraska state Medicaid agency to NSCLC survey of December 1998.

28. Vicky Pulos and Lisa Gallin Lynch, "Outreach Strategies in the State Children's Health Insurance Program," Washington, D.C., Families U.S.A. (June 1998) at 11.

29. Letter of June 7, 1999 to State Medicaid Directors from Sally K. Richardson, Director, Center for Medicaid and State Operations, available on HCFA website at www.hcfa.gov/Medicaid/smd6799a.htm.

30. 42 U.S.C. § 426 provides the basic entitlement to premium-free Part A Medicare for those entitled to Social Security benefits. Individuals with insufficient earnings to qualify for cash benefits and thus for Part A include women who never married and have no work history, and domestic and migrant workers whose employers did not report earnings to Social Security.

31. The initial Medicare enrollment period is the seven months surrounding the beneficiary's 65th birthday: three months before, the birthday month and three months following the birthday. 42 U.S.C. § 1395p(d) & (e).

32. The fourteen month loss of coverage would occur if an individual tried to apply for QMB in April, had to wait until the following January to enroll in Medicare Part A, with benefits not beginning until July 1. Thus, the individual would have had to wait from May of one year through June of the following year for coverage.

33. A chart prepared by the Health Care Financing Administration dated 2/10/99 lists each state's FY 1998 allocation, the amount spent for QI-1s, for QI-2s, the total spent and the remaining allocation. The total spent is $2,687,184 of $200,000,000, or 1.3 percent. An article in the New York Times of January 23, 1999 entitled "Medicare Safety Nets Fail To Catch Many of the Poor," by Peter T. Kilborn attributes to Marilyn Moon of the Urban Institute the estimate that only 16,000 of a 500,000 potentially eligible were enrolled in the QI program in 1998.

34. "Shortchanged," *supra* note 5 at 13.

35. Alabama is the only state that reported such a dramatic departure from SSI rules. According to a report prepared for HCFA by the American Public Human Services Association, both New York and Massachusetts eliminate asset requirements for part of their buy-in population (New York for SLMBs and QIs; Massachusetts for disabled individuals), but New York Medicaid officials did not report this on their survey response and Massachusetts Medicaid officials did not respond to the survey. By contrast to this small number, 36 states have eliminated the asset requirement in their Medicaid program for children, according to the Center for Budget and Policy Priorities. *See* Letter of January 23, 1998 to State Health Officials from Nancy Ann Min-DeParle and Claude Fox concerning outreach and enrollment in Medicaid and the Children's Health Insurance Program, available at http://www.hcfa.gov/init/choutrch.htm

36. The states are DC, FL, HI, ME, MA, MS, NE, NJ, PA, SC, UT, VT as reported in AARP, *supra* note 5. at Appendix 3. Florida covers individuals with incomes up to 90% of poverty, rather than 100% of poverty.

37. 42 U.S.C. § 1396d(p)(2)(A).

38. See *Rehabilitation Association of Virginia v. Kozlowski*, 42 F.3d 1444 (4th Cir. 1994); *Haynes Ambulance Serv. Inc. v. Alabama,* 36 F.3d 1074 (11th Cir. 1994); *Pennsylvania Medical* Society v. Snider & Shalala, 29 F.3d 886 (3d Cir. 1994); *New York City Health and Hospitals Corporation v. Perales and Sullivan*, 954 f. 2d 854 (2d Cir. 1992)

39. "Variations," *supra* note 5.

40. See, Affidavit of Charles S. Amorosino, Jr., Executive Vice President of the Florida Medical Association before the State of Florida's Division of Administrative Hearings, *Irene Reynolds v. State of Florida, Agency for Health Care Administration*, Case No. 96-1682 RX, May 22, 1996, ¶ 6: "Because of the lower reimbursement level of QMBs, many FMA members have limited or ceased their participation in the Medicaid program.

41. Sec. 4714 (a)(3)(A) & (B) of the Balanced Budget Act, Pub. L. 105-33.

42. Fact Sheet, "Medicare Managed Care," The Henry J. Kaiser Family Foundation, July 1999, Figure 1.

43. Kaiser Key Facts, *supra* note 1. According to this Fact Sheet, about 4.5% of the 6 million dually-eligible Medicare beneficiaries are enrolled in Medicare managed care. By contrast, about 12.7% of all Medicare beneficiaries are enrolled in Medicare managed care.

44. 42 U.S.C. §1396d(p)(3). State Medicaid Manual, Part 3 (HCFA-Pub. 45-3) § 3490.12 Medicare Cost Sharing Expenses and Federal Financial Participation.

45. *Id.* According to the Kaiser Foundation Fact Sheet on Medicare Managed Care, *supra* note 42, nearly two-thirds of Medicare HMOs do not charge a premium in addition to the Part B premium charged to all Part B beneficiaries.

46. 42 C.F.R. § 417.460(b) and (c).

47. 42. U.S.C. § 1396a(a)(27).

48. "GAO-99," *supra* note 5.

49. 42 U.S.C. § 1396p(b).

INDIVIDUAL STATE CHARTS

Explanation of Individual State Data Profiles

The following individual state profiles were created from responses to our survey by state Medicaid program staff (Medicaid directors' survey) and by advocates in legal services programs or staff of state health insurance counseling and assistance projects (Advocates' Survey). For 35 states, we have responses to both surveys; for 11 states, we have only the Medicaid agency response; for 3 states, we have only the advocates' response. For three states we received no response, but have included those profiles demographic data and data available from the Healthcare Financing Administration. We have made our best effort to resolve discrepancies in the data through follow-up contacts; where discrepancies could not be resolved, we have reported both the state and the advocates response. The profile below follows the format of the individual data profiles and serves as a guide to interpreting the questions and responses as reported.

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
From HCFA Enrollment Data Base, July 1997, as reported in Rosenbach and Lamphere, "Bridging the Gaps Between Medicare and Medicaid: The Case of QMBs and SLMBs," AARP, January 1999[hereafter "AARP"]

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
Derived by AARP from the March 1996 and 1997 Current Population Surveys, as reported in "AARP."

Total Part B QMBs and SLMBs.
Data on the total number of Part B QMBs and SLMBS are from HCFA's Third Party Premium Billing File, July 1997, as reported in "AARP."

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
As reported in "AARP."

OUTREACH

Outreach Methods/Materials.
Refers to state efforts to reach out to the buy-in population, and the means used.

Availability of Materials in languages other than English.
Refers to state preparation of buy-in materials in other languages.

Receipt and Use of Leads Data.
Refers to state receipt of monthly electronic tapes from the Social Security Administration that identify low-income newly-enrolled Medicare beneficiaries and state uses of the data.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
Refers to state allowing people in other agencies or private organizations to assist individuals in applying for benefits, accept the application and forward it to the state.

Use of Out-Stationed Workers.
Refers to state placement of its own eligibility workers in settings other than welfare offices to certify eligibility for buy-in programs.

Use of Short Form Application.
Refers to state use of a 1-4 page application form for buy-in programs.

Face-to-face interview required.
Refers to state requirement that applicants (or their representatives) have an in-person interview prior to determination of eligibility.

Self-Certification of Income or Resource Data.
Refers to state policy of allowing applicants to declare the truth of their income and resources, in lieu of requiring documentation.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
Refers to Medicaid application process in which either the computer or the worker automatically screens applicant for all buy-in benefits.

Use of Electronic data exchanges for automatic enrollment.
Refers to use of data from which state could determine eligibility for buy-in benefits without an application.

Use of HCFA's System of Conditional Enrollment in Part A
Refers to a process that allows an individual without premium-free Part A to enroll in Part A on the condition that the state will pay the Part A premium through the QMB program.

Part A Buy-in Agreement.
Refers to an agreement between the state and the federal Health Care Financing Administration that allows states to enroll individuals without premium-free Part A in Part A at any time during the year.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Refers to state policy that allows recipients of full Medicaid services who do not have premium-free Part A Medicare also full QMB benefits.

Refers to which, if any, agency and which, if any, advocate responded to the survey.

Explanation of Individual State Data Profiles

ELIGIBILITY

Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.
Refers to state policies that count income or resources more favorably to the applicant than the SSI rules that are normally used for buy-in eligibility determinations.

Use of Family Income Standard.
Refers to a standard, or dollar amount, against which an applicant's income is measured that reflects the actual size of the applicant's family. States not using a family income standard use a one or two person standard (as does SSI), regardless of the actual family size.

MANAGED CARE

State has System for Identifying QMBs Enrolled in Medicare Managed Care.
Refers to a method of identifying Medicare managed care enrollees regardless of when they enroll. In states whose only means of identifying managed care enrollment is through the application process or when a managed care provider bills the state, the answer to this question reflects those limitations.

State Pays Medicare HMO Copays and/or Premiums for QMBs.
Refers to state payment of cost-sharing as well as premiums (in addition to the Part B premium) for QMBs who are enrolled in Medicare HMOs.

QI IMPLEMENTATION

QI Outreach.
Refers to state efforts to reach out to those potentially eligible for the QI program that became effective January 1, 1998.

QI Re-Enrollment.
Refers to state policy and procedure for re-enrolling QIs each year, since, by statute, the benefit "expires" at the end of each year and individuals technically must reapply.

Method of payment of QI-2 benefit.
Refers to state practice for paying the $2.23 per month (in 1999) QI-2 Benefit; states were advised by HCFA that they could pay the benefit in a lump sum at any time during the year.

ADMINISTRATION

QMB Cost Sharing Reimbursement Rate.
Refers to the rate of reimbursement at which Medicaid programs pay Medicare cost-sharing for QMBs. Pursuant to the Balanced Budget Act of 1997, states may, but are not required to, pay at whichever rate – Medicare or Medicaid - is lower for a particular service. Generally, Medicaid rates are lower than Medicare rates.

Estate Recovery.
Refers to state policy of recovering buy-in benefits paid from estates of deceased beneficiaries. By federal law, states are required to recover certain long-term care benefits from the estates of certain Medicaid beneficiaries and they are permitted to recover other benefits. States are not required to recover buy-in benefits.

# of QDWIs.
Refers to the number of Qualified Disabled and Working Individuals the state has enrolled. The survey asked this question because the QDWI program, part of federal work incentive policy for disabled individuals, is underutilized and not very much discussed in the literature. None of the myriad efforts to identify buy-in enrollment rates includes this population.

ALABAMA

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 630,363 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 128,182 ***Total Part B QMBs and SLMBs.*** 37,993 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 29.6%

OUTREACH	***Outreach Methods/Materials.*** State and advocate report that it conducts outreach through flyers sent to district offices, to the Office of Senior Citizens Activities, to a toll-free hotline, and to the Council on Aging. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** Yes. State reports that it sends QMB application to those identified as possible eligibles from the Social Security tapes.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** No one. ***Use of Out-Stationed Workers.*** No. ***Use of Short Form Application.*** Yes. ***Face-to-face interview required.*** No. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** State reports yes; advocate reports it is done for QMB only, not for SLMB,QI or QDWI. ***Use of Electronic data exchanges for automatic enrollment.*** No. State requires a written application. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** State and advocate report yes; HCFAreports no. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** No.

Response to the Alabama survey is from the Alabama Medicaid Agency and Legal Counsel for the Elderly

ALABAMA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** Yes. State totally disregards resources and any income generated by those resources. ***Use of Family Income Standard.*** State reports no.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State reports that it pays the cost share for individuals as long as they go to the HMOs approved provider.For certain QMBs enrolled in an HMO, Medicaid pays a monthly capitation fee, which covers the recipient's copayments.
QI IMPLEMENTATION	***QI Outreach.*** Handouts and speeches to senior citizens groups. ***QI Re-Enrollment.*** State reports that QI-1s and QI-1s are reviewed annually, at which time their income is redetermined. ***Method of payment of QI-2 benefit.*** Lump sum in January.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Generally at the Medicaid rate. ***Estate Recovery.*** No. ***# of QDWIs.*** None.

ALASKA

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 33,737 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 1,252 ***Total Part B QMBs and SLMBs.*** 17 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 1.4%

OUTREACH	***Outreach Methods/Materials.*** State reports that it generally does not conduct outreach due to the small number of people affected. They are involved in a pilot project to reach out to QMBs/SLMBs to encourage enrollment by mail. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** No.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** State reports that a fee agent in Alaskan villages distributes and accepts applications. ***Use of Out-Stationed Workers.*** State reports that applications are taken in tribal offices. ***Use of Short Form Application.*** No. ***Face-to-face interview required.*** Yes, except in very extraordinary circumstances. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** Yes. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Alaska survey are from the Division of Medical Assistance and Alaska Legal Services.

ALASKA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** State reports that it excludes Alaska Longevity Bonus payments, and Alaska Permanent Fund Dividend Payments. Advocate reports that the state has a 'hold harmless' program that makes up for the loss of federal dollars when receipt of a permanent Fund Dividend makes someone ineligible under federal standards. ***Use of Family Income Standard.*** Yes.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** State reports that there are no Medicare HMOs in Alaska. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** Not applicable.
QI IMPLEMENTATION	***QI Outreach.*** State reports that the only QI Outreach conducted is through case worker referral. ***QI Re-Enrollment.*** State reports that QIs will be sent review applications to reapply. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Full Medicare rate. ***Estate Recovery.*** No, although the state has authority to recover these benefits. ***# of QDWIs.*** Two.

ARIZONA

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
601,526

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
85,702

Total Part B QMBs and SLMBs.
33,456

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
39%

OUTREACH

Outreach Methods/Materials.
The state reports using posters, brochures, and a hotline setup by the Aging and Adult Administration. This information is used for public speaking, and is sent to different agencies and organizations. In addition, the state has created many partnerships with different agencies including the aging and adult administration which uses 300 statewide volunteers to go door to door and to Senior Centers. The advocate reports no knowledge of state outreach efforts.

Availability of Materials in languages other than English.
The state reports that its applications, brochures, and posters are available in Spanish. The advocate reports no knowledge of any material printed in other languages.

Receipt and Use of Leads Data.
No.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
No one, but the state allows other entities to distribute the application and it is available on the Internet. All applications must be mailed into the eligibility office or dropped off in person.

Use of Out-Stationed Workers.
No.

Use of Short Form Application.
Yes.

Face-to-face interview required.
State reports that a face-to-face interview is not required for those applying just to the QMB, SLMB, QI-1, and QI-2 program. Those applying for Medicaid benefits are required to have a face-to-face interview.

Self-Certification of Income or Resource Data.
The state reports that it allows applicants to self-certify the truth of their assets, but not their income. The advocate says no.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
State reports it screens SSI-Medicaid only recipients and Arizona long-term care recipients. Advocate says that the state does not screen all applicants.

Use of Electronic data exchanges for automatic enrollment.
Yes. Those with Medicare Part A who receive SSI are matched through SSA.

Use of HCFA's System of Conditional Enrollment in Part A.
Yes.

Part A Buy-in Agreement.
No.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Only for those who apply and are approved.

Responses to the Arizona survey are from the Arizona Health Care Cost Containment System and Community Legal Services.

ARIZONA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** Yes, state uses additional income and resource disregards. Advocate reports no awareness of these. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** Yes, state receives the file from HCFA and matches it against its files. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** No. State reports this is not required under its waiver.
QI IMPLEMENTATION	***QI Outreach.*** State reports letters are sent to all previously denied or discontinued QMBs/SLMBs on select criteria. Advocate reports that the state is making no efforts to enroll QIs. ***QI Re-Enrollment.*** Yes, beneficiaries are sent an application at the end of the year to re-enroll. ***Method of payment of QI-2 benefit.*** Check is given to beneficiary at the time of approval for the entire year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** For Medicare-only services the copayment is based on the Medicare rate; for all other services it is the lower rate of Medicare or Medicaid. ***Estate Recovery.*** No. ***# of QDWIs.*** None.

ARKANSAS

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 411,412 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 83,036 ***Total Part B QMBs and SLMBs.*** 25,748 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 31.0%

OUTREACH	***Outreach Methods/Materials.*** No. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** No.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** State reports that Disproportionate Share Hospitals can accept completed applications. ***Use of Out-Stationed Workers.*** State reports that it outstations 40 permanent workers statewide in hospitals, senior centers, and mental health facilities. ***Use of Short Form Application.*** State reports that its application is four pages. ***Face-to-face interview required.*** Yes. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** State reports that if beneficiary has Part B, it will certify and automatically enroll them into Part A. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Response to the Arkansas survey is from the Department of Human Services.

ARKANSAS

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State pays copays but does not pay premiums.
QI IMPLEMENTATION	***QI Outreach.*** None. ***QI Re-Enrollment.*** State reports that beneficiary's case is reevaluated by means of a new application and a redetermination of income and assets. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Full Medicare rate. ***Estate Recovery.*** No. ***# of QDWIs.*** None.

CALIFORNIA

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 3,546,345 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 560,091 ***Total Part B QMBs and SLMBs.*** 409,217 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 73.1%

OUTREACH	***Outreach Methods/Materials.*** None. ***Availability of Materials in languages other than English.*** State reports none. Advocate reports that application materials and notice of action are available in Spanish. ***Receipt and Use of Leads Data.*** State reports no; HCFA reports yes.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** State reports that nobody can. Advocate mentions community based organizations that are helping Asian Pacific Islander elderly complete applications for QMB. Applications are then turned over to the County personnel for processing. ***Use of Out-Stationed Workers.*** No. ***Use of Short Form Application.*** Yes, a three page application is used. ***Face-to-face interview required.*** No. ***Self-Certification of Income or Resource Data.*** No for QMB/SLMBs. QI-1 and QI-2 applicants do not have to verify resource data. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** No. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** No. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** No.

Responses to the California survey are from the California Department of Health Services, Medi-Cal Eligibility Branch and Center for Health Care Rights.

CALIFORNIA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** Although the state's answer is ambiguous, attachments provided suggest that none are used. ***Use of Family Income Standard.*** State uses standard for the size of the family involved.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** Yes, through a monthly tape match with HCFA. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State does not pay premiums; it pays copays up to the Medicaid rate if providers submit an explanation of benefits.
QI IMPLEMENTATION	***QI Outreach.*** State has asked SSA to do outreach. ***QI Re-Enrollment.*** Counties are responsible for re-enrollment, following normal procedures. ***Methods of payment of QI-2 benefit.*** It is paid annually at the end of each fiscal year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** State pays at the Medicaid rate for dual eligibles (QMB Plus) and Medicare rate for pure QMBs. ***Estate Recovery.*** Yes. ***# of QDWIs.*** None.

COLORADO

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 417,654 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 40,871 ***Total Part B QMBs and SLMBs.*** 12,514 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 30.6%
OUTREACH	***Outreach Methods/Materials.*** State reports that it uses posters and newspapers. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** State reports no, but it is in the process of getting the leads tape.
ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** No one. ***Use of Out-Stationed Workers.*** No. ***Use of Short Form Application.*** No. ***Face-to-face interview required.*** Yes, except for those automatically enrolled through electronic data exchange systems. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** Yes. ***Use of HCFA's System of Conditional Enrollment in Part A.*** State reports yes; advocate reports no. ***Part A Buy-in Agreement.*** No. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** State reports no; advocate reports yes.

Responses to the Colorado survey are from the Colorado Department of Health Care Policy and Financing/Third Party Resources, and Senior Answers and Services.

COLORADO

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** State reports no, adults are considered a household of one.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State reports no; advocate reports yes.
QI IMPLEMENTATION	***QI Outreach.*** State reports that it informs potential beneficiaries about the QI program through notices in newspapers, flyers, and presentations to senior groups; advocate reports that state efforts are limited. ***QI Re-Enrollment.*** State reports that once a year redeterminations are made by mail. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the calendar year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** State reports that it pays the lower of the Medicare or Medicaid rates. ***Estate Recovery.*** State reports that it recovers cost sharing only if beneficiaries are also Medicaid eligible. ***# of QDWIs.*** None.

CONNECTICUT

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 482,612 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 45,606 ***Total Part B QMBs and SLMBs.*** 44,042 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 96.6%

OUTREACH	***Outreach Methods/Materials.*** State reports that it uses brochures. Advocate reports that the state conducts no outreach to potential buy-in beneficiaries, other than possibly public service announcements. ***Availability of Materials in languages other than English.*** State reports yes. The advocate says material for buy-in programs are not available in other languages. ***Receipt and Use of Leads Data.*** No.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** No one. ***Use of Out-Stationed Workers.*** State reports that it out-stations eligibility workers in hospitals. The advocate says the state does not out-station eligibility workers. ***Use of Short Form Application.*** State reports that it does not presently use a short form application, but that it is putting the final changes on one. ***Face-to-face interview required.*** No. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Connecticut survey are from the Department of Social Services and Connecticut Legal Services.

CONNECTICUT

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** Yes, state uses additional income and resource disregards. ***Use of Family Income Standard.*** Yes.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** Yes. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State pays copays; it is unclear if it pays premiums.
QI IMPLEMENTATION	***QI Outreach.*** None. ***QI Re-Enrollment.*** State reports that QI beneficiaries are automatically recertified. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid rate. ***Estate Recovery.*** Yes. ***# of QDWIs.*** None.

DELAWARE

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 100,466 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 12,885 ***Total Part B QMBs and SLMBs.*** 2,388 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 18.5%

OUTREACH	***Outreach Methods/Materials.*** State reports that it distributes flyers, posters, and brochures at health fairs, community events, and senior centers. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** State reports that it receives HCFA leads data, and sends a flier to those potentially eligible.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** No one. ***Use of Out-Stationed Workers.*** Yes. ***Use of Short Form Application.*** Yes. ***Face-to-face interview required.*** Yes. ***Self-Certification of Income or Resource Data.*** State reports that beneficiaries may self-certify their asset information. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Response to the Delaware survey is from the Delaware Division of Social Services.

DELAWARE

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No, but state is considering eliminating the resource test. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** State reports that those buy-in beneficiaries who are enrolled in a managed care plan are identified to the state through the provider or beneficiary, not through information exchange between Medicare and Medicaid programs. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State pays copays but not premiums.
QI IMPLEMENTATION	***QI Outreach.*** State reports that it distributes flyers, posters, and brochures at health fairs, community events, and senior centers. ***QI Re-Enrollment.*** State reports that re-enrollment is done through a complete mail-in application for beneficiaries to verify income and declare assets. ***Method of payment of QI-2 benefit.*** Lump sum at the start of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** State reports that generally the cost sharing reimbursement is at the Medicaid rate. For those Medicare Part B services that are normally not covered under plan, the provider is reimbursed at the full Medicare rate. ***Estate Recovery.*** No. ***# of QDWIs.*** None.

DISTRICT OF COLUMBIA

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 67,765 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 20,027 ***Total Part B QMBs and SLMBs.*** 1,744 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 8.7%

OUTREACH	***Outreach Methods/Materials.*** The District reports that outreach to potential buy-in beneficiaries is done through the use of brochures and notices in the newspaper. The advocate says that she has not seen any outreach efforts by the District. ***Availability of Materials in languages other than English.*** No ***Receipt and Use of Leads Data.*** State reports that it does not know; Advocate believes the District receives leads data but do not use it; HCFA reports the District receives it.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** District reports that workers at other sites can help complete applications but only District workers can determine eligibility. ***Use of Out-Stationed Workers.*** District reports that it does out-station eligibility workers at five community clinics and also pays hospitals $35 per completed application. Advocate believes it is unlikely that these workers take applications for buy-in programs. ***Use of Short Form Application.*** No. ***Face-to-face interview required.*** No answer. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** District reports that it does automatically screen applicants for full Medicaid for buy-in eligibility. Advocate says no, that the District only will enroll an applicant into the buy-in program if the client or the advocate raises the issue after full Medicaid has been denied. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** No. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** District reports that it does pay Part Apremiums for all full Medicaid beneficiaries with incomes less than 100% of poverty. Advocate says that she doesn't think the District pays Part A premiums.

Responses to the District of Columbia's survey are from the Medical Assistance Administration and D.C.

DISTRICT OF COLUMBIA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** No.
QI IMPLEMENTATION	***QI Outreach.*** District reports that it has a contract to develop educational materials for the aging and disabled population. Advocate reports that the District has trained DHS intake staff and has had one meeting with the community to identify what needs to be done. ***QI Re-Enrollment.*** Recertification by mail. ***Method of payment of QI-2 benefit.*** Advocate reports that payments are sent to beneficiaries at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** District reports that it pays the Medicaid rate if it is lower. ***Estate Recovery.*** District reports that it does not recover Medicare cost sharing from the estates of individuals in the buy-in program.The advocate reports that the District puts on its application that it does recover, but that recovery actually occurs on a very limited basis. ***# of QDWIs.*** The District reports that this number is subsumed with their QMB-only category, which is reported to be 45 (as of 2/1/99).

FLORIDA

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 2,615,301 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 366,078 ***Total Part B QMBs and SLMBs.*** 225,589 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 61.6%

OUTREACH	***Outreach Methods/Materials.*** State reports that public information is provided on request.Advocate reports that very little outreach is conducted by the state. ***Availability of Materials in languages other than English.*** State reports no. Advocate reports that general Medicaid program information is provided in Spanish and Creole. ***Receipt and Use of Leads Data.*** State reports that it receives leads data and does nothing with it. Advocate and HCFA report that state does not receive leads data.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** State reports that SSA outreach Demonstration Project in Orlando and Central Miami allows SSA staff to obtain applications. This project will end in December 1999. ***Use of Out-Stationed Workers.*** No. ***Use of Short Form Application.*** State reports yes, perhaps referring to the one-page initial "Request for Assistance" (RFA)for potential beneficiaries to apply for benefits. According to advocate, applicant must then complete a 34-page application with a caseworker through a face-to-face interview. ***Face-to-face interview required.*** State reports yes, except for those parts of the SSAOutreach Demonstration Project going on in Orlando and central Miami area. ***Self-Certification of Income or Resource Data.*** State reports no, except for SSAdemonstration. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** State reports this is done for QMB only. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Florida survey are from the Department of Children and Families and Florida Legal Services.

FLORIDA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** Yes, a more liberal cash resource disregard. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** Yes. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** No.
QI IMPLEMENTATION	***QI Outreach.*** State reports no special outreach beyond sharing memos with Department of Elder Affairs, but state is reviewing all enrolled in medically needy program for QI eligibility. ***QI Re-Enrollment.*** Automatic re-enrollment. ***Method of payment of QI-2 benefit.*** Payment at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid rate. ***Estate Recovery.*** State reports no, but application mentions that state has the right to place a claim against a recipient's estate for benefits paid out. ***# of QDWIs.*** None.

GEORGIA

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 827,559 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 146,968 ***Total Part B QMBs and SLMBs.*** 55,468 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 37.7%

OUTREACH	***Outreach Methods/Materials.*** State reports that it sends a letter to potential eligibles from SSA leads data. ***Availability of Materials in languages other than English.*** State reports no. Advocate reports that all Medicaid program information is available in Spanish. ***Receipt and Use of Leads Data.*** State reports yes; it generates a letter notifying individuals of potential eligibility. Advocate reports that computerized printouts of potential beneficiaries used to be sent to local eligibility offices, but the state has now stopped doing this.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** State reports no one. Advocate reports that anyone can complete and submit an application, but only eligibility workers can accept. ***Use of Out-Stationed Workers.*** State reports that 10 eligibility workers are out-stationed in hospitals. Advocate reports she is unaware of any eligibility workers being out-stationed. ***Use of Short Form Application.*** Yes. ***Face-to-face interview required.*** No answer. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** State reports generally yes, but that QI-1 and QI-2 are not yet automatically screened. ***Use of Electronic data exchanges for automatic enrollment.*** State reports yes for QMBs and SLMBs, and that other group categories are in the process of being connected. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** No.

Responses to the Georgia survey are from the Department of Medical Assistance and Georgia Legal Services.

GEORGIA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** State reports no. Advocate reports that insurance limits are higher. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** No.
QI IMPLEMENTATION	***QI Outreach.*** State reports that it conducts outreach through HI-CARE and public service announcements. ***QI Re-Enrollment.*** State reports that it requires completion of a recertification form; advocate reports that reapplication is required. ***Method of payment of QI-2 benefit.*** Lump sum at the point of eligibility.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid rate. ***Estate Recovery.*** No. ***# of QDWIs.*** Two.

HAWAII

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 144,389 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 21,422 ***Total Part B QMBs and SLMBs.*** 4,077 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 19.0%

OUTREACH	***Outreach Methods/Materials.*** State reports it uses brochures. Advocate reports that flyers have also been used. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** No.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** State reports that outreach facilities can complete application for potential beneficiaries. Advocate reports that no one besides eligibility workers can complete application. ***Use of Out-Stationed Workers.*** Yes, one worker at Hilo Medical Center. ***Use of Short Form Application.*** No. ***Face-to-face interview required.*** State reports that in some circumstances it will allow interviews to be conducted over the phone, or an applicant can send a representative. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Hawaii survey are from the Hawaii Department of Human Services, Med-QUEST division and SAGE PLUS, Executive Office on Aging.

HAWAII

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** Yes, there is no limit on value of household possessions exempted. ***Use of Family Income Standard.*** Yes.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State pays copays but not premiums.
QI IMPLEMENTATION	***QI Outreach.*** State reports that it continues to determine eligibility for full Medicaid and all Medicare beneficiary programs. Advocate reports that the AARP is involved in outreach efforts. ***QI Re-Enrollment.*** State reports that enrollees must complete recertification form and verify income and assets by mail or in person. ***Method of payment of QI-2 benefit.*** Semiannually.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Full Medicare rate. ***Estate Recovery.*** Yes. ***# of QDWIs.*** None.

IDAHO

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 148,231 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 15,047 ***Total Part B QMBs and SLMBs.*** 8,863 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 58.9%

OUTREACH	***Outreach Methods/Materials.*** State reports they use flyers to reach out to potential buy-in beneficiaries. The advocate reports that he is unaware of any outreach efforts by the state. ***Availability of Materials in languages other than English.*** State reports no. Advocate reports that some material is printed in Spanish. ***Receipt and Use of Leads Data.*** No.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** State reports that anyone can accept an application, but that eligibility workers determine if applicant is eligible for benefits. Advocate reports that no one except eligibility workers can accept completed applications. ***Use of Out-Stationed Workers.*** No. ***Use of Short Form Application.*** No. ***Face-to-face interview required.*** No, if applicant cannot arrange to come to a field office. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** No. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Idaho Survey are from the Idaho Department of Health and Welfare and Idaho Legal Aid Services.

IDAHO

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** Yes.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** No.
QI IMPLEMENTATION	***QI Outreach.*** None. ***QI Re-Enrollment.*** State reports that no application is required. Benefits are reissued once address has been verified. ***Method of payment of QI-2 benefit.*** Lump sum at beginning of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicare rate. ***Estate Recovery.*** Yes. ***# of QDWIs.*** None.

ILLINOIS

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 1,536,964 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 155,706 ***Total Part B QMBs and SLMBs.*** 125,739 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 80.8%

OUTREACH	***Outreach Methods/Materials.*** No. ***Availability of Materials in languages other than English.*** State reports that client brochures and notices are available in Spanish. ***Receipt and Use of Leads Data.*** State reports that it receives leads data but does not use it for outreach purposes.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** No one. ***Use of Out-Stationed Workers.*** No. ***Use of Short Form Application.*** Yes. ***Face-to-face interview required.*** No. ***Self-Certification of Income or Resource Data.*** Yes. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** Yes. ***Use of HCFA's System of Conditional Enrollment in Part A.*** No. ***Part A Buy-in Agreement.*** No. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** No.

Response to the Illinois survey is from the Department of Public Aid.

ILLINOIS

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** Yes, the state uses more liberal earned income disregards. ***Use of Family Income Standard.*** Yes.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** No.
QI IMPLEMENTATION	***QI Outreach.*** None. ***QI Re-Enrollment.*** State reports that applicant must reapply. ***Method of payment of QI-2 benefit.*** Annually.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** State reports that it pays the lower rate, whichever that is. ***Estate Recovery.*** State reports that it recovers from the estates of QMBs, but not of other buy-in beneficiaries. ***# of QDWIs.*** None.

INDIANA

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 795,334 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 100,243 ***Total Part B QMBs and SLMBs.*** 60,409 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 60.3%
OUTREACH	***Outreach Methods/Materials.*** State reports that it currently uses flyers and brochures. In addition, it plans to use posters and public service announcements on the television and radio. ***Availability of Materials in languages other than English.*** State reports that it currently does not provide materials in languages other then English, but hopes to start in the summer of 1999. ***Receipt and Use of Leads Data.*** No.
ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** State reports that as of Spring 1999 it has trained volunteers to accept applications at outreach locations. ***Use of Out-Stationed Workers.*** State reports that eligibility workers have attended a few outreach activities. ***Use of Short Form Application.*** Yes. ***Face-to-face interview required.*** No. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** State reports that it uses electronic data exchanges but not for automatic enrollment. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Indiana survey are from the Medicaid Eligibility Unit and the SHIIP program.

INDIANA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** Yes, state uses additional resource disregards. ***Use of Family Income Standard.*** Yes.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** Yes, it pays both.
QI IMPLEMENTATION	***QI Outreach.*** State reports that notices are sent to individuals and that they work with the Hispanic Center in Indianapolis and with AARP on different outreach activities, including some public housing projects. Advocate reports that the state also uses the SHIIP outreach programs. ***QI Re-Enrollment.*** State reports that they redetermine eligibility every 12 months through an interview and a verification of eligibility factors. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Full Medicare rate. ***Estate Recovery.*** Yes. ***# of QDWIs.*** None.

IOWA

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 458,908 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 46,491 ***Total Part B QMBs and SLMBs.*** 41,835 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 90.0%

OUTREACH	***Outreach Methods/Materials.*** State reports that it sends potential eligibles flyers, and that brochures are also given to clients who are inquiring about buy-in benefits. Advocate reports that he is unaware of any outreach efforts by the state. ***Availability of Materials in languages other than English.*** Yes, in Spanish. ***Receipt and Use of Leads Data.*** Yes, mailings are done as time permits.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** No one. ***Use of Out-Stationed Workers.*** State reports that it out-stations two workers at hospitals in Des Moines and is expanding out-stationing to five health centers. Advocate has had no contact with these workers. ***Use of Short Form Application.*** Unclear. ***Face-to-face interview required.*** State reports that they will allow applicant with health problems to be interviewed by phone. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Iowa survey are from the Department of Human Services/Division of Medical Services and H.E.L.P. Legal Assistance office.

IOWA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** No.
QI IMPLEMENTATION	***QI Outreach.*** State reports the use of newspaper articles and cooperation between the AAA and the SHIPP program to reach potential eligibles. ***QI Re-Enrollment.*** State reports that it reviews beneficiary's eligibility, verifies income, and verifies assets only if they are close to the limit. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Full Medicare rate. ***Estate Recovery.*** Yes. ***# of QDWIs.*** Two.

KANSAS

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 371,827 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 43,299 ***Total Part B QMBs and SLMBs.*** 14,964 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 34.6%

OUTREACH	***Outreach Methods/Materials.*** State reports that it uses brochures. Advocate reports she has not seen outreach conducted by the state to potential buy-in beneficiaries. ***Availability of Materials in languages other than English.*** State reports that it prints some materials in Spanish. Advocate reports none. ***Receipt and Use of Leads Data.*** No.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** State reports that no one but eligibility workers can complete application, but some social service agencies will assist individuals with the application. ***Use of Out-Stationed Workers.*** State reports that it does out-station workers to hospitals, FQHCs, Area Agencies on Aging, senior centers, and independent living centers. Advocate reports she has not seen out-stationed workers in other settings. ***Use of Short Form Application.*** No. ***Face-to-face interview required.*** No. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** Yes. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** State reports yes; HCFA reports no. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** No.

Responses to the Kansas survey are from the SRA - Adult and Medical Services Commission and the Legal Aid Society of Topeka.

KANSAS

ELIGIBILITY

Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.
State reports that it uses additional income and resource disregards.

Use of Family Income Standard.
No.

MANAGED CARE

State has System for Identifying QMBs Enrolled in Medicare Managed Care.
No.

State Pays Medicare HMO Copays and/or Premiums for QMBs.
No.

QI IMPLEMENTATION

QI Outreach.
State reports the development of brochures, and the potential for a press release this year. Advocate reports that the eligibility information is present in the field operations manual.

QI Re-Enrollment.
State reports that all QI beneficiaries must have eligibility redetermined yearly. QI-1s are automatically mailed a redetermination form when recertification expires, and QI-2s must reapply within the calendar year.

Method of payment of QI-2 benefit.
Lump sum at the end of the year.

ADMINISTRATION

QMB Cost Sharing Reimbursement Rate.
State reports that cost sharing is generally reimbursed at the Medicaid rate, but if QMB eligible receives non-Medicaid services it is reimbursed at 25% of the Medicare rate.

Estate Recovery.
Yes.

# of QDWIs.
Two.

KENTUCKY

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 576,037 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 97,551 ***Total Part B QMBs and SLMBs.*** 37,027 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 38.0%
OUTREACH	***Outreach Methods/Materials.*** State reports that it uses brochures at public appearances to reinforce information. Advocate reports that she has never seen any outreach information disseminated by the state. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** State reports yes; HCFA reports no.
ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** State reports that some hospitals (DSH) and one federally qualified health center are accepting applications; others are scheduled to accept applications on-line. ***Use of Out-Stationed Workers.*** No. ***Use of Short Form Application.*** Yes. ***Face-to-face interview required.*** Yes, unless the individual receives SSI and is QMB eligible. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** No. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** State and advocate report yes, although HCFA reports they do not. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Kentucky survey are from the Department for Medicaid Services and the Northeast Kentucky Legal Services.

KENTUCKY

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** State reports yes; advocate reports the state only uses a one or two family size.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** Yes. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** Yes, it pays both.
QI IMPLEMENTATION	***QI Outreach.*** State reports that it makes many public appearances and use pamphlets to reinforce information. ***QI Re-Enrollment.*** The state reports that they accept recertification forms by mail. Advocate reports that beneficiaries must go to local offices to verify income and assets. ***Method of payment of QI-2 benefit.*** State reports that they pay a lump sum at the beginning of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid rate. ***Estate Recovery.*** No. ***# of QDWIs.*** Seven.

LOUISIANA

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
560,807

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
94,611

Total Part B QMBs and SLMBs.
29,855

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
31.6%

OUTREACH

Outreach Methods/Materials.
The only outreach it conducts is correspondence.

Availability of Materials in languages other than English.
No.

Receipt and Use of Leads Data.
Yes, it is used to alert staff and to correspond with potentially eligible beneficiaries.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
Enrollment Center Staff.

Use of Out-Stationed Workers.
Yes, permanent Medicaid staff is out-stationed at charity hospitals statewide. The BHSF has solicited and enrolled qualified providers and public agencies as application centers to provide intake and outreach to prospective eligibles.

Use of Short Form Application.
No.

Face-to-face interview required.
Not for those who, due to age or disability, are unable to come to a local office.

Self-Certification of Income or Resource Data.
No.

Automatic Screen All Medicaid applicants for Buy-in Eligibility.
Yes.

Use of Electronic data exchanges for automatic enrollment.
Automatic enrollment of Medicaid recipients with incomes equal to or less than 100% of the poverty level.

Use of HCFA's System of Conditional Enrollment in Part A.
Yes.

Part A Buy-in Agreement.
No, has not found automatic enrollment of all uninsured 65 years and over to be cost effective.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
No information provided.

Responses to the Louisiana survey are from Louisiana Medicaid Program, Bureau of Health Services Financing Third Party/Medicaid Recovery and The Advocacy Center

LOUISIANA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** No, income is allocated to ineligible children. Remaining countable income is compared to either individual or couple standard. If only one member of a couple is applying, that individual must be income eligible based on his/her income alone.

MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** Yes, HCFA GHP master magnetic tape. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** No, but it is implementing a process.

QI IMPLEMENTATION	***QI Outreach.*** HCFA leads data are used. ***QI Enrollment.*** Applications are mailed to all previously certified. ***Methods of payment of QI-2 benefit.*** Lump sum at the end of the year.

ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Full Medicare rate. ***Estate Recovery.*** No. ***# of QDWIs.*** None.

MAINE

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
198,229

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
26,155

Total Part B QMBs and SLMBs.
15,992

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
61.1%

OUTREACH

Outreach Methods/Materials.
State reports that it sends flyers to 7,000 pharmacists, town offices, ME state housing residents, and Home Health Agencies for their statewide newsletter. Advocate reports use of brochure by aging organizations.

Availability of Materials in languages other than English.
No.

Receipt and Use of Leads Data.
No.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
No one.

Use of Out-Stationed Workers.
No.

Use of Short Form Application.
Yes.

Face-to-face interview required.
No Answer.

Self-Certification of Income or Resource Data.
No.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
Yes.

Use of Electronic data exchanges for automatic enrollment.
No.

Use of HCFA's System of Conditional Enrollment in Part A.
Yes.

Part A Buy-in Agreement.
Yes.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Yes.

Responses to the Maine survey are from the Bureau of Medical Services, Division of Policy Development, and Pine Tree Legal Services.

MAINE

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** Yes. ***Use of Family Income Standard.*** State reports no, that they provide an income allocation to children.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** State reports that there are no HMOs at this time. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** N/A.
QI IMPLEMENTATION	***QI Outreach.*** State reports that they have mailed out 7,000 flyers to pharmacists, Home Health Agencies, and town offices. Advocate reports that they have not seen any of the state's outreach efforts. ***QI Re-Enrollment.*** State reports it automatically reviews QI-1 beneficiaries for eligibility, while QI-2 beneficiaries must reapply for benefits. ***Method of payment of QI-2 benefit.*** Lump sum for the year at time of approved application.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Full Medicare rate. ***Estate Recovery.*** State reports that it does not actively recover from the estates of beneficiaries, but the application does state that recovery can occur. ***# of QDWIs*** No answer.

MARYLAND

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 578,683 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 57,374 ***Total Part B QMBs and SLMBs.*** 47,773 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 83.3%

OUTREACH	***Outreach Methods/Materials.*** State reports yes. Advocate reports that she has not seen any of the state's outreach efforts, but understands clients receive letters about buy-in. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** State reports yes, that it generates names and mails letters.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** No one. ***Use of Out-Stationed Workers.*** No. ***Use of Short Form Application.*** No. ***Face-to-face interview required.*** Yes. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** State reports yes. Advocate reports that the state manual directs workers to do so, but that it does not happen. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** State reports yes. Advocate reports no, that when applicants sign up for Medicare they then apply at DSS for QMB and get reimbursed by SSAafter the buy-in benefits kick in. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Maryland survey are from the Medical Care Policy Administration and Legal Aid Bureau.

MARYLAND

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** State reports yes, through its Medicaid Management Information System. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** No.
QI IMPLEMENTATION	***QI Outreach.*** State reports that it conducts outreach through state Office on Aging and its local affiliates. ***QI Re-Enrollment.*** Recertification. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid rate. ***Estate Recovery.*** Yes. ***# of QDWIs.*** Not available.

MASSACHUSETTS

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
883,181

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
107,107

Total Part B QMBs and SLMBs.
121,913

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
113.8%*

OUTREACH

Outreach Methods/Materials.
Advocate reports that the state uses flyers, and that Social Security Offices will refer people seeking widow benefits to the Department of Medical Assistance to apply (under a demonstration project ending December 1999).

Availability of Materials in languages other than English.
Advocate reports that they have not seen materials in languages other than English.

Receipt and Use of Leads Data.
HCFA reports no.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
Advocate reports no one.

Use of Out-Stationed Workers.
No.

Use of Short Form Application.
For SLMB, QI-1 and QI-2 only.

Face-to-face interview required.
No answer.

Self-Certification of Income or Resource Data.
Advocate reports yes for SLMBs and QIs, but not for QMB or QDWI.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
Yes.

Use of Electronic data exchanges for automatic enrollment.
No answer.

Use of HCFA's System of Conditional Enrollment in Part A.
Advocate reports yes.

Part A Buy-in Agreement.
Advocate reports yes.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Advocate reports yes, if they are aware of it.

Response to the Massachusetts survey is from Greater Boston Legal Services.

*As reported in "AARP." According to the report, "participation rates in Massachusetts and Mississippi may exceed 100 percent for several reasons: (1) lack of precision of the denominator low-income Medicare beneficiaries, which are based on survey data; (2) inclusion of Medicare beneficiaries under age 65 in the counts of QMBs/SLMBs and exclusion of those under age 65 from the counts of low-income Medicare Part B beneficiaries; and (3) more generous allowance of income in the eligibility determination process due to income disregards (this is, income that is not counted in determining eligibility.)"

MASSACHUSETTS

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources*** Advocate reports no. ***Use of Family Income Standard.*** Advocate reports not being sure.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** Advocate reports no. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** Advocate reports not being sure.
QI IMPLEMENTATION	***QI Outreach.*** Advocate reports that the state sent out a brochure to advocates in March 1999. In addition, the state provides brochures on request to advocates to aid them in outreach efforts to potential eligibles. ***QI Re-Enrollment.*** Advocate reports recertification by mail. ***Method of payment of QI-2 benefit.*** Advocate reports a lump sum towards the beginning of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Advocate reports the Medicaid rate. ***Estate Recovery.*** Advocate reports probably not. ***# of QDWIs.*** No Answer.

MICHIGAN

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 1,310,738 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 163,510 ***Total Part B QMBs and SLMBs.*** 51,614 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 31.6%

OUTREACH	***Outreach Methods/Materials.*** State reports that it engages in outreach. Advocate reports that she has only seen brochures in county welfare offices. ***Availability of Materials in languages other than English.*** State reports no. Advocate reports that all forms are available in Spanish and Arabic. ***Receipt and Use of Leads Data.*** State reports yes. Advocate and HCFA report no.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** State reports that other agencies administer certain aspects of the program. Advocate reports that no one else can. ***Use of Out-Stationed Workers.*** Yes, workers are outstationed in hospitals. ***Use of Short Form Application.*** No. ***Face-to-face interview required.*** No answer. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** Yes. ***Use of HCFA's System of Conditional Enrollment in Part A.*** State is not familiar with this process. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Michigan survey are from the Department of Community Health and Medicare/Medicaid Assistance Program.

MICHIGAN

ELIGIBILITY

Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.
No.

Use of Family Income Standard.
No answer.

MANAGED CARE

State has System for Identifying QMBs Enrolled in Medicare Managed Care.
State reports yes, through computer coding. Advocate reports no.

State Pays Medicare HMO Copays and/or Premiums for QMBs.
Yes, it pays both.

QI IMPLEMENTATION

QI Outreach.
State reports that it makes pamphlets available to the Michigan Family Independence Agency, Hospitals, Long-term Care Agencies, Other Provider Offices, and Community Agencies as Requested. Advocate reports that she has not seen any of the state's outreach efforts.

QI Re-Enrollment.
State reports that applicant must reapply in person or by mail and provide verification of income and assets for eligibility determination. State also uses BENDEX tape match, which allows its system to verify certain income information.

Method of payment of QI-2 benefit.
Annually.

ADMINISTRATION

QMB Cost Sharing Reimbursement Rate.
Medicaid rate.

Estate Recovery.
No.

# of QDWIs.
No answer.

MINNESOTA

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
611,177

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
107,030

Total Part B QMBs and SLMBs.
20,164

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
18.8%

OUTREACH

Outreach Methods/Materials.
State reports that brochures are available to county social service agencies, advocate and provider organizations. In addition, mailings are sent to potential Medicare beneficiaries, direct information is sent to providers, presentations to specific groups/communities, toll free information line, newspaper press releases, and public service announcements on the radio.

Availability of Materials in languages other than English.
State reports that application forms, civil rights brochures, and verification request forms are available in Spanish, Hmong, Cambodian, Laotian, Russian, and Vietnamese. Advocate reports that he has not seen any information published in languages other than English.

Receipt and Use of Leads Data.
State reports it uses data to send outreach mailings to potential QMB, SLMB, QI, and QWDI beneficiaries.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
State reports that it allows providers, advocacy organizations, and other grantees under contract with the state to accept completed applications for potential beneficiaries.

Use of Out-Stationed Workers.
State reports that each county in the Twin Cities metro area has one or two full time staff on-site at local hospitals. Staff is also available when requested to take applications at senior centers, advocacy organizations, and health centers. Advocate questions whether these workers process buy-in applications.

Use of Short Form Application.
No.

Face-to-face interview required.
No.

Self-Certification of Income or Resource Data.
State reports no for income verification, but yes for assets that are self-declared to be more than $300 under the program asset limit for the applicable household size. Advocate reports no.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
Yes, though advocate suggests it may depend on the financial worker spotting eligibility based on data provided.

Use of Electronic data exchanges for automatic enrollment.
No.

Use of HCFA's System of Conditional Enrollment in Part A.
Yes.

Part A Buy-in Agreement.
Yes.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Yes.

Responses to the Minnesota survey are from the Department of Human Services and the Southern Minnesota Regional Legal Services, Inc.

MINNESOTA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** Yes, State reports using several more liberal income and resource disregards. ***Use of Family Income Standard.*** Yes.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** State reports it is notified by the recipient or the provider. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** Yes, state pays copays; it also pays premiums when it is determined to be cost-effective.
QI IMPLEMENTATION	***QI Outreach.*** State reports that outreach mailings are sent to recipients who are identified to be potentially eligible for program benefits. In addition, there is a distribution of brochures and application materials to advocacy groups and organizations that serve the elderly and persons with disabilities and information sessions at tribal centers. ***QI Re-Enrollment.*** State reports that individual must complete a recertification form and return it by mail to the social service agency. Verification of income must be included, but not assets, unless they are within $300 of the program asset limit. ***Method of payment of QI-2 benefit.*** Annual lump sum paid at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicare rate. ***Estate Recovery.*** Yes. ***# of QDWIs.*** Two.

MISSISSIPPI

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 389,433 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 69,929 ***Total Part B QMBs and SLMBs.*** 77,872 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 1.114*

OUTREACH	***Outreach Methods/Materials.*** State reports that pamphlets and brochures are available at Medicaid office explaining all coverage groups. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** Yes. A letter is generated as a notice to call in.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** No one. ***Use of Out-Stationed Workers.*** No. ***Use of Short Form Application.*** No. ***Face-to-face interview required.*** No. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Response to the Mississippi survey is from the Division of Medicaid.

*As reported in "AARP". According to the report, "participation rates in Massachusetts and Mississippi may exceed 100 percent for several reasons: (1) lack of precision for the denominator low-income Medicare beneficiaries, which are based on survey data; (2) inclusion of Medicare beneficiaries under age 65 in the counts of QMBs/SLMBs and exclusion of those under age 65 from the counts of low-income Medicare Part B beneficiaries; and (3) more generous allowance of income in the eligibility determination process due to income disregards (that is, income that is not counted in determining eligibility.)"

MISSISSIPPI

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** Yes, the state uses many more liberal resource methodologies. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** State reports that there are no Medicare HMOs in Mississippi. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** Not applicable.
QI IMPLEMENTATION	***QI Outreach.*** No answer. ***QI Re-Enrollment.*** State reports that beneficiary must complete a recertification form by mail or by telephone. ***Method of payment of QI-2 benefit.*** Lump sum at the beginning of the year.
ADMINISTRATION	**QMB Cost Sharing Reimbursement Rate.** Medicaid rate. ***Estate Recovery.*** No. ***# of QDWIs.*** One.

MISSOURI

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 805,846 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 100,424 ***Total Part B QMBs and SLMBs.*** 65,411 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 65.1%

OUTREACH	***Outreach Methods/Materials.*** ***Availability of Materials in languages other than English.*** ***Receipt and Use of Leads Data.*** HCFA reports yes.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** ***Use of Out-Stationed Workers.*** ***Use of Short Form Application.*** ***Face-to-face interview required.*** ***Self-Certification of Income or Resource Data.*** ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** ***Use of Electronic data exchanges for automatic enrollment.*** ***Use of HCFA's System of Conditional Enrollment in Part A.*** ***Part A Buy-in Agreement.*** HCFA reports no. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.***

No response to the Missouri survey was received from either the state or an advocate.

MISSOURI

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** ***Use of Family Income Standard.***
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** ***State Pays Medicare HMO Copays and/or Premiums for QMBs.***
QI IMPLEMENTATION	***QI Outreach.*** ***QI Re-Enrollment.*** ***Method of payment of QI-2 benefit.***
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate*** ***Estate Recovery.*** ***# of QDWIs.***

MONTANA

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 127,389 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 14,812 ***Total Part B QMBs and SLMBs.*** 10,938 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 73.8%

OUTREACH	***Outreach Methods/Materials.*** No. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** No.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application*** No one. ***Use of Out-Stationed Workers.*** No. ***Use of Short Form Application.*** No. ***Face-to-face interview required.*** No. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** State reports yes, for SSI-cash recipients. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Response to the Montana survey is from the Department of Public Health and Human Services.

MONTANA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** No answer.
QI IMPLEMENTATION	***QI Outreach.*** State reports that it has developed pamphlets for county offices, senior centers, and aging bureaus. ***QI Re-Enrollment.*** State reports that beneficiary must complete a recertification form and reverify income and assets, which can be done by mail. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** State reports that it pays the lowest of actual charge, Medicare or Medicaid rate. ***Estate Recovery.*** Yes. ***# of QDWIs.*** None.

NEBRASKA

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 240,544 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 32,862 ***Total Part B QMBs and SLMBs.*** 2,124 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 6.5%

OUTREACH	***Outreach Methods/Materials.*** State reports that brochures are made available to hospital and Aging Centers. ***Availability of Materials in languages other than English.*** State reports that the program application is available in Spanish. ***Receipt and Use of Leads Data.*** State reports it receives leads data; HCFAreports it does not.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** State reports that hospital outreach workers can accept completed applications. ***Use of Out-Stationed Workers.*** State reports the use of out-stationed workers in hospitals. ***Use of Short Form Application.*** No. ***Face-to-face interview required.*** State reports that a representative can be sent in the place of an applicant. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** No. ***Part A Buy-in Agreement.*** State reports it has a Part A buy-in agreement, HCFA reports it does not. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** No.

Response to the Nebraska survey is from the Nebraska Department of Health and Human Services.

NEBRASKA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** Yes.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care*** State reports that it finds out when a provider sends an Explanation of Benefits. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** Yes it pays both.
QI IMPLEMENTATION	***QI Outreach.*** State reports that it uses pamphlets which are for the full Medicaid program. ***QI Re-Enrollment.*** State reports that beneficiaries must fill out a reapplication by mail to verify income and resources. ***Method of payment of QI-2 benefit.*** Yearly.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid Rate. ***Estate Recovery.*** No. ***# of QDWIs.*** One.

NEVADA

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 198,316 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 30,092 ***Total Part B QMBs and SLMBs.*** 13,550 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 45.0%

OUTREACH	***Outreach Methods/Materials.*** State reports no. Advocate reports that brochures are available on request from community agencies. ***Availability of Materials in languages other than English.*** State reports no; advocate reports general Medicaid information available in Spanish. ***Receipt and Use of Leads Data.*** No.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** State reports no one. Advocate reports that hospitals, nursing homes, and social services accept completed applications. ***Use of Out-Stationed Workers.*** Yes, in a few hospitals. ***Use of Short Form Application.*** No. ***Face-to-face interview required.*** No. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** State reports no. Advocate reports yes. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Nevada survey are from the Division of Health Care Financing and Policy, and Washoe Co. Senior Law Program.

NEVADA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** State reports that applicants are asked to provide information regarding third party liability (TPL) and often their cards have an HMO sticker. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State reports yes for both. Advocate reports no.
QI IMPLEMENTATION	***QI Outreach.*** None. ***QI Re-Enrollment.*** State reports that beneficiaries must complete a recertification application that verifies their income and resources. This application can be completed and sent in the mail. ***Method of payment of QI-2 benefit.*** State reports that it pays the QI-2 benefits at the end of the year depending on available funding.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid rate. ***Estate Recovery.*** Yes. ***# of QDWIs.*** None.

NEW HAMPSHIRE

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
151,586

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
17,777

Total Part B QMBs and SLMBs.
1,432

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
8.1%

OUTREACH

Outreach Methods/Materials.
State reports that it distributes brochures to the NHDHHS offices, city/town welfare offices, CAP agencies, nutrition sites, senior centers, libraries, hospitals, doctor offices, and senior housing. In addition, the state is in the process of developing flyers, posters, and public service announcements on the radio. Advocate reports no knowledge of the state's activities.

Availability of Materials in languages other than English.
State reports that it is in the process of developing materials in both Spanish and French-Canadian. Advocate says no.

Receipt and Use of Leads Data.
No.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
State reports that trained volunteer counselors from the Health Insurance Counseling Education and Assistance (HICEAS) and employees of the New Hampshire Housing Authority may accept completed applications to be mailed to local district offices.

Use of Out-Stationed Workers.
No.

Use of Short Form Application.
Yes, used at public housing locations and by HICEAS volunteers.

Face-to-face interview required.
No Answer.

Self-Certification of Income or Resource Data.
No.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
State reports that the computer does not automatically screen but the interview process does include a screen. Advocate reports yes.

Use of Electronic data exchanges for automatic enrollment.
No.

Use of HCFA's System of Conditional Enrollment in Part A.
Yes.

Part A Buy-in Agreement.
Yes.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Yes.

Responses to the New Hampshire survey are from the Division of Family Assistance, Division of Elderly and Adults, Division of Community and Public Health, and New Hampshire Legal Assistance.

NEW HAMPSHIRE

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** None that apply to buy-in applicants. ***Use of Family Income Standard.*** Yes.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State pays copays but not premiums.
QI IMPLEMENTATION	***QI Outreach.*** State reports that brochures have been developed and are distributed by the State Health Insurance Counseling Education Assistance Services program and their 200 counselors. ***QI Re-Enrollment.*** State reports that beneficiary must reapply by mail to verify income and assets. ***Method of payment of QI-2 benefit.*** Lump sum paid at the beginning of the eligibility period.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicare rate. ***Estate Recovery.*** Yes. ***# of QDWIs.*** Three.

NEW JERSEY

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
1,123,792

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
148,126

Total Part B QMBs and SLMBs.
102,049

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
68.9%

OUTREACH

Outreach Methods/Materials.
State reports that it sends direct mailings to potential eligibles who are enrolled in the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program.

Availability of Materials in languages other than English.
State reports no; advocate reports some materials are in Spanish.

Receipt and Use of Leads Data.
No.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
No one.

Use of Out-Stationed Workers.
State reports using out-stationed workers in large hospitals; they take QMB but not SLMB or QI applications.

Use of Short Form Application.
State reports that it uses a short form for SLMB and QI enrollment.

Face-to-face interview required.
Not for SLMB or QI.

Self-Certification of Income or Resource Data.
State reports that self-certification is allowed only for SLMB and the QI programs. These cases are verified though state income tax matches. Advocate reports no, that the state takes a couple of months to verify information.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
Yes.

Use of Electronic data exchanges for automatic enrollment.
Yes.

Use of HCFA's System of Conditional Enrollment in Part A.
Yes.

Part A Buy-in Agreement.
No.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Yes.

Responses to the New Jersey survey are from the Division of Medical Assistance and Health Services and the Union County Legal Services Corp.

NEW JERSEY

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** Yes, but only in situations where a child is eligible for buy-in.

MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State does not pay copays; it pays premiums if it is cost effective to do so.

QI IMPLEMENTATION	***QI Outreach.*** State reports that eligibility file of state program is used to outreach if reported income is below QI level. Advocate has not seen any of the state's outreach efforts. ***QI Re-Enrollment.*** Complete a recertification form by mail. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.

ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid rate. ***Estate Recovery.*** No. ***# of QDWIs.*** None.

NEW MEXICO

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 207,430 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 40,816 ***Total Part B QMBs and SLMBs.*** 9,551 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 23.4%

OUTREACH	***Outreach Methods/Materials.*** No. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** Yes; the state sends people a general notice asking them to come into the office.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** State reports that it allows the State Agency on Aging to accept applications and send them into the Medicaid office by mail. ***Use of Out-Stationed Workers.*** No. ***Use of Short Form Application.*** State reports that the QMB, SLMB, and QI programs use the short form application. ***Face-to-face interview required.*** No answer. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** No. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** No. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** No.

Response to the New Mexico survey is from the Human Services Department-Medical Assistance.

NEW MEXICO

ELIGIBILITY

Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.
State reports yes; QMB clients who live with an ineligible spouse receive an income disregard of the difference between the individual and couple standard and total income is compared to the couple income standard.

Use of Family Income Standard.
No.

MANAGED CARE

State has System for Identifying QMBs Enrolled in Medicare Managed Care.
No.

State Pays Medicare HMO Copays and/or Premiums for QMBs.
No.

QI IMPLEMENTATION

QI Outreach.
State reports that based on leads data, it sends a notice asking individuals to apply for the QMB, SLMB, or QI program at a local office.

QI Re-Enrollment.
Cases needed to be recertified every 12 months to verify income and resources.

Method of payment of QI-2 benefit.
State reports that it has not implemented the QI-2 program.

ADMINISTRATION

QMB Cost Sharing Reimbursement Rate.
Medicaid rate.

Estate Recovery.
No.

# of QDWIs.
None.

NEW YORK

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
2,491,742

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
399,444

Total Part B QMBs and SLMBs.
168,694

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
42.2%

OUTREACH

Outreach Methods/Materials.
State reports that it works closely with the State Office for the Aging and AARP to publicize these programs and is also involved in a large mailing with the Health Care Financing Administration to 54,000 low-income Medicare beneficiaries.

Availability of Materials in languages other than English.
The state reports that it prints all notices and some applications in Spanish. The simplified applications for SLMB,QI-1, and QI-2 are only available in English.

Receipt and Use of Leads Data.
No.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
State reports that applications can be accepted at senior action centers, but eligibility is determined by an employee of the local department of social services. Advocate reports that no one except eligibility workers can accept completed applications.

Use of Out-Stationed Workers.
Yes, at Senior Centers.

Use of Short Form Application.
Yes, for SLMB, QI-1, and QI-2.

Face-to-face interview required.
Yes.

Self-Certification of Income or Resource Data.
No.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
Yes.

Use of Electronic data exchanges for automatic enrollment.
Yes.

Use of HCFA's System of Conditional Enrollment in Part A.
State reports yes. Advocate reports that conditional enrollment is only from January to March 31 in a given year.

Part A Buy-in Agreement.
No.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
No.

Responses to the New York survey are from the NYS Department of Health and the Brookdale Center on Aging.

NEW YORK

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** The state determines HMO enrollment during the application process. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State reports that it only pays the HMO coinsurance for QMBs if the provider is enrolled in Medicaid; it pays premiums in some circumstances.
QI IMPLEMENTATION	***QI Outreach.*** State reports that it works closely with the State Office for the Aging and AARP to publicize these programs and is also involved in a large mailing with HCFAto 54,000 Medicare beneficiaries. ***QI Re-Enrollment.*** State reports for the year of 1999 it is extending buy-in benefits through 12/31/99 and asking recipient to contact their local department of social services if there have been any income or resource changes. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Full Medicare rate. ***Estate Recovery.*** Yes. ***# of QDWIs.*** State reports that no documentation is available.

NORTH CAROLINA

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
1,029,266

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
178,780

Total Part B QMBs and SLMBs.
45,454

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
25.4%

OUTREACH

Outreach Methods/Materials.
State reports that it uses flyers and public service announcements on the radio and television.

Availability of Materials in languages other than English.
No.

Receipt and Use of Leads Data.
Yes, county agencies screen existing clients for eligibility.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
No one.

Use of Out-Stationed Workers.
State reports that it out-stations eligibility workers in hospitals, FQHCs, RHCs, Public Health, and Senior Centers.

Use of Short Form Application.
No.

Face-to-face interview required.
Yes, but state is developing a mail-in form for aged, blind, and disabled population.

Self-Certification of Income or Resource Data.
No.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
Yes.

Use of Electronic data exchanges for automatic enrollment.
No.

Use of HCFA's System of Conditional Enrollment in Part A.
Yes.

Part A Buy-in Agreement.
Yes.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Yes.

Responses to the North Carolina survey are from the Department of Medical Assistance and Provider Services, and Legal Services of Southern Piedmont, Inc.

NORTH CAROLINA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** State requests this information in the application process. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** No.
QI IMPLEMENTATION	***QI Outreach.*** State reports that it has developed a fact sheet on the conditions for eligibility and Medicaid services available to each group, client brochures, articles for advocates' newsletters and providers' bulletins, page on website, radio and newspaper PSAs, and short program for AM radio. Advocate reports that the state has not started much of the outreach described. ***QI Re-Enrollment.*** Recertification form may be mailed in. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid rate. ***Estate Recovery.*** State reports that estate recovery is not implemented for QMB/SLMB-only recipients. ***# of QDWIs.*** One.

NORTH DAKOTA

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
98,995

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
15,219

Total Part B QMBs and SLMBs.
1,724

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
11.3%

OUTREACH

Outreach Methods/Materials.
State reports that it conducts no outreach. Advocate reports that the state provides brochures at the County Social Services Office.

Availability of Materials in languages other than English.
No.

Receipt and Use of Leads Data.
No.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
No one.

Use of Out-Stationed Workers.
State reports that it does not out-station eligibility workers. Advocate reports that there are some eligibility workers out-stationed to hospitals and federally qualified health centers: however, these workers might not accept buy-in applications.

Use of Short Form Application.
No.

Face-to-face interview required.
No.

Self-Certification of Income or Resource Data.
No.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
State reports that it does automatically screen for buy-in eligibility when someone applies for full Medicaid. Advocate reports that this may vary from county to county.

Use of Electronic data exchanges for automatic enrollment.
No.

Use of HCFA's System of Conditional Enrollment in Part A.
State reports yes. Advocate reports no.

Part A Buy-in Agreement.
Yes.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
State reports no. Advocate reports yes.

Responses to the North Dakota survey are from the Department of Human Services - Medicaid Division, and Legal Assistance of North Dakota, Inc.

NORTH DAKOTA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** Yes, state uses more liberal income and resource disregards. Advocate reports no awareness of these. ***Use of Family Income Standard.*** Yes.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** Advocate reports that there are no Medicare HMOs in North Dakota. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** Not applicable.
QI IMPLEMENTATION	***QI Outreach.*** State reports that eligibility workers discuss QI program with other applicants and recipients, updates were made to the Medicaid brochure, and presentations were made to other groups. Advocate reports no awareness of any QI outreach sponsored by the state. ***QI Re-Enrollment.*** Recertification form verifying income and assets. ***Method of payment of QI-2 benefit.*** Lump sum paid out at the beginning of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Full Medicare rate. ***Estate Recovery.*** Yes. ***# of QDWIs.*** None.

OHIO

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 1,609,631 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 192,028 ***Total Part B QMBs and SLMBs.*** 85,207 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 44.4%

OUTREACH	***Outreach Methods/Materials.*** No. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** State reports yes, as of January 6, 1999.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application*** No one. ***Use of Out-Stationed Workers.*** No. ***Use of Short Form Application.*** State reports it is currently in the process of developing one. ***Face-to-face interview required.*** State reports that it currently requires a face-to-face interview of an applicant or a representative. It is modifying its application process for buy-in programs to allow for mail-in. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Ohio survey are from the Department of Human Services and Advocates for Basic Legal Equality, Inc.

OHIO

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** No.
QI IMPLEMENTATION	***QI Outreach*** State reports that it is reviewing ways to conduct outreach, as part of the effort to streamline the application process. ***QI Re-Enrollment*** State reports that beneficiaries must reapply for benefits, including verification of income and assets. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate*** Medicaid rate. ***Estate Recovery*** No. ***# of QDWIs*** Three.

OKLAHOMA

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 473,630 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 75,771 ***Total Part B QMBs and SLMBs.*** 62,564 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 82.6%

OUTREACH	***Outreach Methods/Materials.*** State reports none is conducted. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** State reports receiving it; HCFA reports no.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** No one. ***Use of Out-Stationed Workers.*** State reports that five workers are out-stationed to take all types of Medicaid applications at Social Security Offices. In addition, several FQHC's and two hospitals have out-stationed workers. Advocate is not aware of any out-stationed workers. ***Use of Short Form Application.*** No. ***Face-to-face interview required.*** No answer. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Oklahoma survey are from Health Care Authority and the Legal Aid of Western Oklahoma.

OKLAHOMA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** Both state and advocate reported yes, but the example they gave did not fall within this concept. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State pays copays but not premiums.
QI IMPLEMENTATION	***QI Outreach.*** State reports that it is currently participating in the SSA pilot project to out-station DHS workers in SSA offices to take applications for QMB, SLMB, and QI-s. Advocate is unaware of state's outreach effort. ***QI Re-Enrollment.*** State reports that QI-1s will complete an annual recertification, and QI-2s have to reapply yearly. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid rate. ***Estate Recovery.*** No. ***# of QDWIs.*** Two.

OREGON

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 453,009 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 41,142 ***Total Part B QMBs and SLMBs.*** 30,247 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 73.5%

OUTREACH	***Outreach Methods/Materials.*** Advocate reports state uses brochures. ***Availability of Materials in languages other than English.*** Yes: Spanish, Russian, Vietnamese, Hmong and three others. ***Receipt and Use of Leads Data.*** HCFA reports no.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** No one. ***Use of Out-Stationed Workers.*** Advocate reports state has workers at certain hospitals. ***Use of Short Form Application.*** Yes. ***Face-to-face interview required.*** No answer. ***Self-Certification of Income or Resource Data.*** Yes. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** Yes. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** HCFA reports no. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Response to the Oregon survey is from the Oregon Law Center.

OREGON

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** Advocate reports no. ***Use of Family Income Standard.*** Yes.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** No.
QI IMPLEMENTATION	***QI Outreach.*** Advocate reports none. ***QI Re-Enrollment.*** Advocate reports an annual review is conducted by mail. ***Method of payment of QI-2 benefit.*** A lump sum annually.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid rate. ***Estate Recovery.*** Yes. ***# of QDWIs.*** None.

PENNSYLVANIA

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
1,987,217

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
263,809

Total Part B QMBs and SLMBs.
123,490

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
46.8%

OUTREACH

Outreach Methods/Materials.
State reports that it uses brochures for its outreach effort. Advocate reports that the Department of Aging has recently begun sending flyers with pharmaceutical benefit cards and meals on wheels. In addition, the Department of Aging is working on a video for public access television and information is available on their website.

Availability of Materials in languages other than English.
State reports that brochures are available in Spanish. Advocate reports that the brochure is outdated.

Receipt and Use of Leads Data.
State receives leads data; it is developing a program to notify potential beneficiaries.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
State reports that Area Agency on Aging, hospitals, nursing homes and various other agencies can accept completed applications.

Use of Out-Stationed Workers.
State reports no. Advocate reports that an eligibility worker is out-stationed in SSAoffices, through a demonstration project in one county.

Use of Short Form Application.
Yes, a four page application is used for SLMB and QI.

Face-to-face interview required.
No answer.

Self-Certification of Income or Resource Data.
No.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
State reports yes. Advocate reports yes, but that few eligibility workers are aware of the QI program because the state has failed to update its handbooks.

Use of Electronic data exchanges for automatic enrollment.
Yes.

Use of HCFA's System of Conditional Enrollment in Part A.
Yes.

Part A Buy-in Agreement.
Yes.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Yes.

Responses to the Pennsylvania survey are from the Division of Health Services, Office of Income Maintenance, and the Elderly Law Project of Community Legal Services, Inc.

PENNSYLVANIA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** Yes.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** Only through Third Party Liability questions on application. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State pays copays but not premiums.
QI IMPLEMENTATION	***QI Outreach.*** State says that they sent out a press release at the QI program's inception. ***QI Re-Enrollment.*** State reports that beneficiary must complete a recertification each year by mail, so that the state can verify income and assets. Advocate reports that often state workers are telling beneficiaries that they must submit the forms in person. ***Method of payment of QI-2 benefit.*** State reports that an annual lump sum payment is paid at the time of the application, and then annually at the recertification.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid rate. ***Estate Recovery.*** No. ***# of QDWIs.*** State is not able to identify these people separately.

RHODE ISLAND

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
156,981

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
42,685

Total Part B QMBs and SLMBs.
1,779

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
4.2%

OUTREACH

Outreach Methods/Materials.
Flyers distributed at community centers, senior centers, and community organizations; public service announcements on radio.

Availability of Materials in languages other than English.
No.

Receipt and Use of Leads Data.
No.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
No one.

Use of Out-Stationed Workers.
No.

Use of Short Form Application.
Short form is used only for the QI program.

Face-to-face interview required.
No answer.

Self-Certification of Income or Resource Data.
Self-certification of income and resources for QI program only.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
No.

Use of Electronic data exchanges for automatic enrollment.
Yes, but only for SSI eligibles.

Use of HCFA's System of Conditional Enrollment in Part A.
State reports that it is reviewing process. Advocate reports yes.

Part A Buy-in Agreement.
Yes.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Yes.

Responses to the Rhode Island survey are from the Center for Adult Health of the Department of Human Services, and Rhode Island Legal Services.

RHODE ISLAND

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** State reports that it is planning to use a family standard in the future. Advocate reports that the state uses a family standard for SSI only.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** Only using the Third Party Liability verification process. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State pays copays but not premiums.
QI IMPLEMENTATION	***QI Outreach.*** State reports that it reaches potential eligibles through mailings, Senior Centers, and subsidized housing; advocate reports that state collaborates with AARP and the Department of Elder Affairs. ***QI Re-Enrollment.*** Recertification by mail. ***Method of payment of QI-2 benefit.*** Answer unclear.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid rate. ***Estate Recovery.*** No. ***# of QDWIs.*** None.

SOUTH CAROLINA

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
510,103

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
89,628

Total Part B QMBs and SLMBs.
88,949

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
99.2%

OUTREACH

Outreach Methods/Materials.
State reports that outreach is not done on an ongoing basis. Advocate reports that the state mails flyers to the Aging Network, Veterans Administration, and residential care facilities. In addition, brochures are mailed to Aging Network and to beneficiaries.

Availability of Materials in languages other than English.
No.

Receipt and Use of Leads Data.
State reports that it receives leads data but it does not use it. Advocate reports that the state receives leads data on the tape and then a hard copy is sent to the state DSS and they follow-up with the leads.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
State reports that it allows Area Agencies on Aging to accept completed applications for eligibility.

Use of Out-Stationed Workers.
No.

Use of Short Form Application.
Yes.

Face-to-face interview required.
No, if application is complete and information is not questionable.

Self-Certification of Income or Resource Data.
No.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
Yes.

Use of Electronic data exchanges for automatic enrollment.
Yes.

Use of HCFA's System of Conditional Enrollment in Part A.
Yes.

Part A Buy-in Agreement.
State did not respond; HCFA data show the state does not have an agreement.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Yes.

Responses to the South Carolina survey are from the Department of Health and Human Services and South Carolina Appleseed Legal Justice Center

SOUTH CAROLINA

ELIGIBILITY

Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.
The state reports that it uses more liberal resource exclusion for QMBs and SLMBs, but not QIs.

Use of Family Income Standard.
State reports that it does not, but will make allocations for minor children, in rare situations.

MANAGED CARE

State has System for Identifying QMBs Enrolled in Medicare Managed Care.
No.

State Pays Medicare HMO Copays and/or Premiums for QMBs.
No.

QI IMPLEMENTATION

QI Outreach.
State reports a special blitz week in 1998 targeting the QI population. Advocate reports that newspaper articles were used and flyers were mailed to the aging network, VA, and residential care facilities. In addition brochures were mailed to beneficiaries and handed out at group presentation.

QI Re-Enrollment.
State reports that recipients must complete a recertification form by mail.

Method of payment of QI-2 benefit.
Lump sum at the end of the year.

ADMINISTRATION

QMB Cost Sharing Reimbursement Rate.
Full Medicare rate.

Estate Recovery.
No.

# of QDWIs.
None.

SOUTH DAKOTA

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
112,505

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
19,350

Total Part B QMBs and SLMBs.
5,841

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
30.2%

OUTREACH

Outreach Methods/Materials.
Advocate reports that the state has a limited supply of brochures. State workers often use a brochure printed and distributed by the Senior Health Information and Insurance Education (SHIINE) program.

Availability of Materials in languages other than English.
No.

Receipt and Use of Leads Data.
The state forwards leads data to the SHINE program. The SHINE program using its own funds, sends out a mailing to promote the QMB, SLMB and QI-1 programs.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
No one.

Use of Out-Stationed Workers.
No.

Use of Short Form Application.
No.

Face-to-face interview required.
No answer.

Self-Certification of Income or Resource Data.
No.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
Advocate reports no, that applicants must apply specifically for different programs.

Use of Electronic data exchanges for automatic enrollment.
No.

Use of HCFA's System of Conditional Enrollment in Part A.
Yes.

Part A Buy-in Agreement.
HCFA reports yes.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Yes.

Response to the South Dakota survey is from the State Health Information and Insurance Education (SHINE).

SOUTH DAKOTA

ELIGIBILITY

Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.
Unclear.

Use of Family Income Standard.
Yes.

MANAGED CARE

State has System for Identifying QMBs Enrolled in Medicare Managed Care.
Advocate reports that there are no Medicare HMOs in South Dakota.

State Pays Medicare HMO Copays and/or Premiums for QMBs.
Not applicable.

QI IMPLEMENTATION

QI Outreach.
None.

QI Re-Enrollment.
Advocate reports that beneficiaries must reapply and verify income and assets, usually through a visit to the DSS office.

Method of payment of QI-2 benefit.
Lump sum.

ADMINISTRATION

QMB Cost Sharing Reimbursement Rate.
Medicaid rate.

Estate Recovery.
No.

# of QDWIs.
No answer provided.

TENNESSEE

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 757,279 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 151,532 ***Total Part B QMBs and SLMBs.*** 69,045 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 45.6%

OUTREACH	***Outreach Methods/Materials.*** State reports that Legal Services conducts outreach though a grant for the QMB/SLMB programs. Advocate reports that flyers are sent to those who call the QMB hotline, but the state does not advertise the number. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** No.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** No one. ***Use of Out-Stationed Workers.*** Yes, in hospitals and, according to advocate, in some social services agencies. ***Use of Short Form Application.*** Yes. ***Face-to-face interview required.*** State reports that it will schedule a home visit or phone interview if warranted; advocate reports buy-in applications can be done by mail or telephone. ***Self-Certification of Income or Resource Data.*** State reports no. Advocate reports yes, unless information seems questionable. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** State reports yes, except for QDWIs. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Tennessee survey are from the Department of Health, Bureau of TennCare, and Legal Aid Society of Middle Tennessee.

TENNESSEE

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** Yes.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State pays copays when it is billed; it does not pay premiums.
QI IMPLEMENTATION	***QI Outreach.*** State reports that workers discuss the QI program when individuals apply to other programs. ***QI Re-Enrollment.*** Reapplication by mail is required. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** State reports that the Medicaid rate is paid for IP hospital,OP hospital, SNF, and physician service bills. The Medicare rate is paid for all other services. ***Estate Recovery.*** No. ***# of QDWIs.*** None.

TEXAS

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 2,053,070 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 394,938 ***Total Part B QMBs and SLMBs.*** 111,572 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 28.3%

OUTREACH	***Outreach Methods/Materials.*** State reports using flyers for QMB, SLMB, and QI. ***Availability of Materials in languages other than English.*** Yes, Spanish. ***Receipt and Use of Leads Data.*** State and advocate both report receipt of leads data; HCFA, however, reports no receipt by the state.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** No one. ***Use of Out-Stationed Workers.*** No. ***Use of Short Form Application.*** Yes. ***Face-to-face interview required.*** State reports that if a face-to-face interview cannot be conducted, it will do a phone interview. ***Self-Certification of Income or Resource Data.*** Yes. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** State reports that it uses electronic data exchanges to enroll QMBs. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Texas survey are from the Department of Human Services.

TEXAS

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** No.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care*** Yes, the state has a tape exchange with HCFA. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State reports that as of 11/1/99, the state will be paying HMO copays, but not premiums.
QI IMPLEMENTATION	***QI Outreach.*** State reports that its outreach efforts rely on flyers, which are available in English or Spanish. In addition, they respond to inquiries from federal mail-outs. ***QI Re-Enrollment.*** Beneficiaries must reapply. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** State reports that it pays whichever rate is lower. ***Estate Recovery.*** No. ***# of QDWIs.*** One.

UTAH

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
183,403

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
13,424

Total Part B QMBs and SLMBs.
11,228

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
83.6%

OUTREACH

Outreach Methods/Materials.
State reports that it uses brochures and conducts presentations to potentially eligible people at mostly senior centers. Advocate has not seen any outreach conducted by the state.

Availability of Materials in languages other than English.
The state reports that it is currently translating information on Medicare cost-sharing programs and Medicaid, as well as its applications, into Spanish.

Receipt and Use of Leads Data.
Yes. Data are sent to county offices that decide how to use it.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
State reports that staff from Aging Services, Services for People with Disabilities, and Mental Health often complete applications with their clients. The advocate reports that long-term care facilities staff will help with the completion of applications.

Use of Out-Stationed Workers.
State reports that it is out-stationing workers at hospitals, community health centers, local health departments, shelters, and nursing homes. Advocate reports that they have not seen any out-stationed eligibility workers.

Use of Short Form Application.
State reports that it currently does not use a short form, but is drafting one.

Face-to-face interview required.
No.

Self-Certification of Income or Resource Data.
No.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
Yes.

Use of Electronic data exchanges for automatic enrollment.
State reports that it uses electronic data exchanges to see if it can add someone already on Medicaid to the QMB or SLMB program. The advocate says that to his knowledge nobody is ever automatically enrolled into the buy-in program.

Use of HCFA's System of Conditional Enrollment in Part A.
State reports it will cover Part A premiums if a QMB eligible person is not entitled to Medicaid; it does not say how this is accomplished.

Part A Buy-in Agreement.
No.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
No.

Responses to the Utah survey are from the Department of Health and Health Care Financing, and Utah Legal Services

UTAH

ELIGIBILITY

Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.
No.

Use of Family Income Standard.
No.

MANAGED CARE

State has System for Identifying QMBs Enrolled in Medicare Managed Care.
Utah has no Medicare HMOs.

State Pays Medicare HMO Copays and/or Premiums for QMBs.
Not applicable.

QI IMPLEMENTATION

QI Outreach.
State reports that it is currently not doing any specific campaigns to inform potentially eligible recipients. It will be conducting more presentations during the coming year, increasing direct mailings, and working on the SSA project to inform more people.

QI Re-Enrollment.
State reports that it automatically re-enrolls beneficiaries, but reviews their income and resources every 12 months.

Method of payment of QI-2 benefit.
Lump sum at the end of the year.

ADMINISTRATION

QMB Cost Sharing Reimbursement Rate.
Medicaid rate.

Estate Recovery.
Yes.

# of QDWIs.
None.

VERMONT

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 81,312 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 9,109 ***Total Part B QMBs and SLMBs.*** 5,030 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 55.2%

OUTREACH	***Outreach Methods/Materials.*** ***Availability of Materials in languages other than English.*** ***Receipt and Use of Leads Data.*** HCFA reports no.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** ***Use of Out-Stationed Workers.*** ***Use of Short Form Application.*** ***Face-to-face interview required.*** ***Self-Certification of Income or Resource Data.*** ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** ***Use of Electronic data exchanges for automatic enrollment.*** ***Use of HCFA's System of Conditional Enrollment in Part A.*** ***Part A Buy-in Agreement.*** HCFA reports yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.***

No response to the Vermont survey was received from either the state or an advocate.

VERMONT

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** ***Use of Family Income Standard.***
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** ***State Pays Medicare HMO Copays and/or Premiums for QMBs.***
QI IMPLEMENTATION	***QI Outreach.*** ***QI Re-Enrollment.*** ***Method of payment of QI-2 benefit.***
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** ***Estate Recovery.*** ***# of QDWIs.***

VIRGINIA

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 802,387 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 156,097 ***Total Part B QMBs and SLMBs.*** 47,559 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 30.5%

OUTREACH	***Outreach Methods/Materials.*** State reports that it uses a Medicaid handbook and fact sheets, and a training event to potential buy-in beneficiaries. Advocate reports that she has not seen any of the state's outreach materials. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** No.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** No one. ***Use of Out-Stationed Workers.*** State reports that it has a total of 67 out-stationed eligibility workers at various sites including hospitals and health departments. ***Use of Short Form Application.*** No. ***Face-to-face interview required.*** No answer. ***Self-Certification of Income or Resource Data.*** No. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** State reports yes. Advocate reports no. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** No. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the Virginia survey are from the Department of Medical Assistance Services and the Virginia Poverty Law Center.

VIRGINIA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** State reports no. Advocate reports that a few more liberal resource policies are used. ***Use of Family Income Standard.*** State reports yes. Advocate reports no.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** Only through the application process. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State pays copays where a provider bills the state; it does not pay premiums.
QI IMPLEMENTATION	***QI Outreach.*** State reports that information is available on its website, and a separate fact sheet has been developed as an all-purpose handout on QI coverage. ***QI Re-Enrollment.*** Reapplication. ***Method of payment of QI-2 benefit.*** Lump sum paid at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid. ***Estate Recovery.*** Yes. ***# of QDWIs.*** Fewer than five.

WASHINGTON

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
672,178

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
76,597

Total Part B QMBs and SLMBs.
33,451

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
43.7%

OUTREACH

Outreach Methods/Materials.
State reports that it has made brochures available at SSAoffices, senior centers, and welfare offices. Advocate reports that she has not seen any state outreach efforts.

Availability of Materials in languages other than English.
State reports that it offers its QMB brochure and QI-2 applications in Spanish, Russian, Vietnamese, Cambodian, Chinese, Korean, and Laotian.

Receipt and Use of Leads Data.
No.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
State reports that no one can. Advocate notes that social workers from hospitals might help potential beneficiaries complete application, and then send to the Medicaid office.

Use of Out-Stationed Workers.
State reports no. Advocate reports that there are five or six state workers in her county outstationed to hospitals and community health centers to enroll people in Medicaid.

Use of Short Form Application.
State reports that only the QI-2 application is one page, and the other programs are integrated into one application which is six pages long.

Face-to-face interview required.
No.

Self-Certification of Income or Resource Data.
No, but state is evaluating self-declaration of income and elimination of assets test.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
Yes.

Use of Electronic data exchanges for automatic enrollment.
No.

Use of HCFA's System of Conditional Enrollment in Part A.
State reports yes. Advocate reports that in theory this can be done, but local welfare offices are not always aware of it.

Part A Buy-in Agreement.
Yes.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Yes.

Responses to the Washington survey are from the State Department of Social and Health Services, Medical Assistance Administration, Division of Client Support and Columbia Legal Services.

WASHINGTON

ELIGIBILITY

Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.
State reports it is currently using the SSI methodology for cost-sharing programs. They hope to implement some more Liberal methodologies starting in June of 1999.

Use of Family Income Standard.
Yes.

MANAGED CARE

State has System for Identifying QMBs Enrolled in Medicare Managed Care.
No.

State Pays Medicare HMO Copays and/or Premiums for QMBs.
State reports that it pays copays and premiums for QMBs.

QI IMPLEMENTATION

QI Outreach.
State reports that its staff has attended conferences and has given presentations and workshops for clients, providers and advocates for the elderly and disabled. In addition, information has been shared with community based organizations such as AARP, Asian/Pacific Island Elderly programs, Senior Services and SSA offices. Advocate reports that a lot was done when program first was started, but she has not seen much activity recently.

QI Re-Enrollment.
State reports that QI-I beneficiaries must complete and eligibility review form and mail it back with income and assets verified. QI-2 clients must return by mail an application form. This must be done by April.

Method of payment of QI-2 benefit.
Annual lump sum.

ADMINISTRATION

QMB Cost Sharing Reimbursement Rate.
State reports that they generally pay at the Medicaid rate or whichever rate is lower.

Estate Recovery.
No.

# of QDWIs.
Nine.

WEST VIRGINIA

DEMOGRAPHICS	***Total Number of Medicare Part B Beneficiaries.*** 320,076 ***Number of Low-Income Medicare Beneficiaries Age 65 and Over.*** 69,313 ***Total Part B QMBs and SLMBs.*** 42,959 ***QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.*** 62.0%

OUTREACH	***Outreach Methods/Materials.*** None. ***Availability of Materials in languages other than English.*** No. ***Receipt and Use of Leads Data.*** State reports this is unknown; HCFAreports no.

ENROLLMENT	***Who Besides Eligibility Workers Can Accept Completed Application.*** No one. ***Use of Out-Stationed Workers.*** State reports that it out-stations approximately 10 hospital workers. ***Use of Short Form Application.*** Yes. ***Face-to-face interview required.*** No. ***Self-Certification of Income or Resource Data.*** Yes. ***Automatic Screen of All Medicaid applicants for Buy-in Eligibility.*** Yes. ***Use of Electronic data exchanges for automatic enrollment.*** No. ***Use of HCFA's System of Conditional Enrollment in Part A.*** Yes. ***Part A Buy-in Agreement.*** Yes. ***Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.*** Yes.

Responses to the West Virginia survey are from the Office of Family Support and the Bureau for Medical Services of the Department of Health and Human Resources.

WEST VIRGINIA

ELIGIBILITY	***Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.*** No. ***Use of Family Income Standard.*** Yes.
MANAGED CARE	***State has System for Identifying QMBs Enrolled in Medicare Managed Care.*** No. ***State Pays Medicare HMO Copays and/or Premiums for QMBs.*** State reports it has no recipients enrolled in Medicare HMOs.
QI IMPLEMENTATION	***QI Outreach.*** State reports that all applicants for all programs are screened for eligibility automatically by the data system. ***QI Re-Enrollment.*** Recertification by mail. ***Method of payment of QI-2 benefit.*** Lump sum at the end of the year.
ADMINISTRATION	***QMB Cost Sharing Reimbursement Rate.*** Medicaid rate. ***Estate Recovery.*** No. ***# of QDWIs.*** None.

WISCONSIN

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
738,626

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
83,734

Total Part B QMBs and SLMBs.
23,987

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
28.6%

OUTREACH

Outreach Methods/Materials.
State reports using a full range of outreach materials for the entire Medicaid population, not specifically directed to the buy-in population; advocate reports no awareness of the state's efforts.

Availability of Materials in languages other than English.
No answer provided.

Receipt and Use of Leads Data.
State and advocate both report receipt of leads data; HCFA, however, reports no receipt by the state.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
State reports no one. Advocate reports that the County Department on Aging outstations employees to accept but not process applications.

Use of Out-Stationed Workers.
Yes.

Use of Short Form Application.
No.

Face-to-face interview required.
Yes.

Self-Certification of Income or Resource Data.
No.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
Yes, but advocate reports not for QI or QDWI.

Use of Electronic data exchanges for automatic enrollment.
State reports yes. Advocate reports no.

Use of HCFA's System of Conditional Enrollment in Part A.
No.

Part A Buy-in Agreement.
Yes.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Yes.

Responses to the Wisconsin survey are from the Department of Health and Family Services and Senior Law, Legal Action of Wisconsin.

WISCONSIN

ELIGIBILITY

Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.
No.

Use of Family Income Standard.
No.

MANAGED CARE

State has System for Identifying QMBs Enrolled in Medicare Managed Care.
No.

State Pays Medicare HMO Copays and/or Premiums for QMBs.
State reports yes for copays; advocate reports no. State does not pay premiums.

QI IMPLEMENTATION

QI Outreach.
State reports that state offers fact sheets. Advocate reports that the state sent a letter to senior centers and advocacy groups.

QI Re-Enrollment.
A 12-month eligibility review is scheduled and completed by an eligibility worker.

Method of payment of QI-2 benefit.
Lump sum paid at the end of the year.

ADMINISTRATION

QMB Cost Sharing Reimbursement Rate.
Medicaid rate.

Estate Recovery.
State reports yes. Advocate reports no.

# of QDWIs.
None.

WYOMING

DEMOGRAPHICS

Total Number of Medicare Part B Beneficiaries.
59,927

Number of Low-Income Medicare Beneficiaries Age 65 and Over.
7,758

Total Part B QMBs and SLMBs.
2,612

QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over.
33.7%

OUTREACH

Outreach Methods/Materials.
State reports that its flyers are under development, and that brochures are available from County DFS offices. Advocate reports that flyers are distributed to outreach network partners and SHIP volunteers, and that public service announcements appear in newspapers.

Availability of Materials in languages other than English.
No.

Receipt and Use of Leads Data.
Yes, a notice is sent to each individual about the programs and where to apply.

ENROLLMENT

Who Besides Eligibility Workers Can Accept Completed Application.
State reports that individuals and providers can assist potential buy-in beneficiaries and send them into the Department of Family Services. It trains staff at hospitals, RHCs, FQHCs CHCs, homeless shelters, public health centers, nursing homes, and senior centers to assist applicants. Advocate reports that SHIP volunteers can complete applications.

Use of Out-Stationed Workers.
No.

Use of Short Form Application.
Yes.

Face-to-face interview required.
No.

Self-Certification of Income or Resource Data.
No.

Automatic Screen of All Medicaid applicants for Buy-in Eligibility.
Yes.

Use of Electronic data exchanges for automatic enrollment.
No.

Use of HCFA's System of Conditional Enrollment in Part A.
No, it is not necessary.

Part A Buy-in Agreement.
Yes.

Payment of Part A Premiums of Beneficiaries Who Also Receive Full Medicaid.
Yes.

Responses to the Wyoming survey are from Health Care Financing and State of Wyoming Insurance Department.

WYOMING

ELIGIBILITY

Use and Description of Methodologies More Liberal Than SSI for Determining Income and Resources.
No.

Use of Family Income Standard.
State reports no but that a deduction for each dependent is applied.

MANAGED CARE

State has System for Identifying QMBs Enrolled in Medicare Managed Care.
There are no Medicare HMOs in Wyoming.

State Pays Medicare HMO Copays and/or Premiums for QMBs.
Not applicable.

QI IMPLEMENTATION

QI Outreach.
State reports that it has a flier that can be inserted into various mailings and has been distributed to many organizations. The state also continues to work with JOIN (Joint Outreach Information Network), which is a an informal group of government agencies and advocates to resolve health related problems.

QI Re-Enrollment.
State reports that individuals must verify income and assets to re-enroll.

Method of payment of QI-2 benefit.
Lump sum at the end of the year.

ADMINISTRATION

QMB Cost Sharing Reimbursement Rate.
Full Medicare rate.

Estate Recovery.
No.

# of QDWIs.
None.

APPENDICES

APPENDIX ONE:

Survey of State Medicaid Directors
Survey Instrument

MEDICAID BUY IN: SURVEY OF STATE MEDICAID DIRECTORS

N.B. The term buy-in is used in this survey to refer to all of the Medicaid categories that pay some or all of the Medicare cost-sharing for certain individuals: Qualified Medicare Beneficiary (QMB) including those receiving full Medicaid, Specified Low Income Medicare Beneficiary (SLMB) including those receiving full Medicaid, Qualified Disabled Working Individual (QDWI) and Qualified Individual-1 and -2 (QI-1 and QI-2)

Outreach

1. Do you conduct outreach to potential buy-in beneficiaries? (Yes/No).
If so, what forms of outreach do you use and where?
Fliers _____
Posters _____
Brochures _____
Public service announcements on radio _____
Public service announcements on TV _____
Other? _____ If any of the above, please attach a copy of each.

2. Do you print program information in languages other than English?
(Yes/No). Which languages? _____
Which program information? _____

3. Do you have screening tools available to non-profits, providers and other federal, state and local government agencies to screen for buy-in eligibility? (Yes/No).
How and to whom are they distributed? _____
_____
_____

Enrollment

4. Do you allow individuals other than your own eligibility workers to accept completed applications for potential beneficiaries? (Yes/No) If so, whom? _____
_____
_____

How are such applications transmitted to you?_____
_____

5. Do you outstation eligibility workers to take applications for buy-in Benefits at locations other than the state or county welfare/Medicaid office? (Yes/No). If so, how many workers are outstationed, how often and where? (At hospitals, community health centers, senior centers, other? Be specific) _____
_____
_____

6. Do you use a short form (1-3 pages maximum) application for QMB, SLMB, QDWI, QI enrollment? (If the answer varies according to program, please indicate). _____
_____
If so, please attach a copy. If not, how long is the application form you use?
_____

7. Do you allow applicants for buy-in benefits to self-certify, under penalty of law, the truth of their income and asset information? (Yes/No) If not, what are the barriers to adopting such a policy?
_____
_____
_____

8. Do you get leads data (HCFA's monthly list of newly enrolled Medicare beneficiaries with Title II incomes at or below 100% of federal poverty guidelines)? (Yes/No)
What do you do with it? (Be specific). _____
_____
_____

Do you evaluate the effectiveness of your efforts to use it? (Yes/No). If so, please share the results of your evaluations.

9. Are all your full Medicaid recipients with incomes below 100% of poverty (both cash benefit recipients and non-cash recipients) automatically enrolled as QMBs? (Yes/No) Does your answer include those for whom you must pay the Part A premium because they are not entitled to premium-free Part A? (Yes/No) If the answer to either question is no,

Please explain the process required for these individuals to become QMBs.
_____
_____
_____

10. Do you certify nursing home residents on Medicaid as QMBs if their income is less than 100% of poverty? (Yes/No) If not, why not? _____
_____
Is this done automatically during the eligibility process? (Yes/No) If not, how is it done? _____
_____
_____

11. When someone applies for full Medicaid, does that application include an automatic screen for buy-in eligibility (all categories: QMB, SLMB, QI, QDWI) (Yes/No) If not, please explain what an applicant would have to do to become enrolled in one of the buy-in programs. _____
_____
_____

12. Do you use any electronic data exchanges systems (SDX, BENDEX or other) to automatically enroll as QMB, SLMB, QI or QDWI individuals for whom you have access to all or nearly all eligibility information? (Yes/No) If so, please explain for whom and how this is done. _____
_____
_____

Eligibility

13. Do you use income or resource methodologies (under 42 U.S. C. § 1396a(r)(2)) for buy-in program eligibility that differ from those used for SSI? (Yes/No). If yes, please describe specifically what the different methodologies are and for which buy-in categories they are used. _____
_____
_____
_____

14. Do you use a family standard for buy-in eligibility that reflects the actual size of the family involved (i.e., if the applicant is in a family of five, do you measure income against the income poverty guideline for a family of five)? (Yes/No)
If not, why not? _____
_____
_____

Copayment issues

15. Do you pay Medicare cost-sharing for QMBs who also have full Medicaid? (i.e., in addition to Medicare premiums, do you pay co-payments and deductibles for QMBs with full Medicaid)? (Yes/No)

16. Do you pay cost-sharing at the full Medicare rate or only at the Medicaid rate if that is lower? (Full/Medicaid rate) Please specify if the answer differs according to type of provider or type of service, or if it differs according to whether the beneficiary is QMB-only or QMB with full Medicaid._____
_____
_____
_____

17. Do you pay the Part A SNF coinsurance for QMBs in nursing homes for Medicare days 21-100? (Yes/No) If not, why not? _____
_____
_____

18. Do you have a way of finding out that a full-Medicaid-QMB or a QMB-only is enrolled in a Medicare HMO? (Yes/No) If yes, what is it? _____
_____
_____

19. Do you pay HMO coinsurance for QMBs who are enrolled in Medicare HMOs? (Yes/No) If not, why not? _____
_____
_____

20. Do you pay HMO premiums for QMBs enrolled in Medicare HMOs? (Yes/No) If not, why not? _____
_____
_____

21. What steps are you taking to address cost-sharing issues for QMBs enrolling in new Medicare+Choice plans (such as how to treat copayments for a dually-eligible individual in a Medicare private fee-for-service plan)? _____
_____
_____
_____

Part A issues

22. Do you honor conditional enrollment into Medicare Part A for a QMB application? [HCFA allows low-income individuals without premium-free Part A to enroll in Medicare Part A on the condition that the state will pay their Part A premium as a QMB. Once an individual has completed the conditional enrollment form, s/he takes a copy of the form to the state Medicaid office and can be enrolled as a QMB] (Yes/No) If not, why not?

_____
_____
_____

23. Do you have a Part A buy-in agreement with HCFA? (Yes/No) If not, why not? _____
_____
_____

If so, and if it were possible to modify your agreement to have HCFA automatically enroll in Part A and then in QMB all SSI recipients who do not have premium-free Part A, would you do it? (Yes/No) If not, why not?

_____
_____

24. Do you pay Part A premiums for all full Medicaid beneficiaries who do not have premium-free Part A Medicare and who have incomes less than 100% of poverty? (Yes/No)

QI implementation

25. How many QI-1s have you enrolled since January 1, 1998? _____

How many QI-2s have you enrolled since January 1, 1998? _____

26. What efforts are you making to inform potential beneficiaries about the Qualified Individual program? Please be as specific and inclusive as possible. _____
_____
_____
_____

27. What is required of an individual receiving QI-1 or QI-2 benefits at the end of one year in order to re-enroll I the program for the following year? (Will they have to reapply at the office? Complete a recertification form by mail? Verify income and assets?)

_____
_____
_____

28. Are you informing applicants for QI-1 or QI-2 status in writing of their right to a fair hearing if they are denied QI status? (Yes/No) If not, why not?

_____
_____
_____

29. Describe the training given to your eligibility workers on QI program requirements. (Attach any materials used). _____
_____
_____
_____

30. How are you paying the QI-2 benefit (lump sum at beginning of year, at end of year, monthly, quarterly, semi-annually)? _____
_____
_____

Program Administration

31. What categories are included in your buy-in agreement with HCFA (see attached copy of 42 C.F.R. ß 407.42 for a listing of the categories)? _____
_____
_____
_____

32. Do you recover Medicare cost sharing from the estates of individuals who were QMB-only, SLMB-only, QDWI or QI? (Yes/No) What does your application for buy-in benefits say about estate recovery?

_____
_____
_____
_____

33. What is required to be a Medicaid provider in your state? (e.g., does the provider have to complete an application? If so, what does the application ask? How long is it? If not, can a provider merely submit a claim to Medicaid and thus be considered a Medicaid provider? How does a provider get a Medicaid provider number? How does one submit a claim to Medicaid?) _____
_____
_____
_____

34. How many QDWIs are enrolled in your state? _____

35. How have you informed providers of their obligation, under the Balanced Budget Act, to take assignment for all Qualified Medicare Beneficiaries and not to bill the beneficiary for any cost-sharing? _____
_____
_____

Thank you for the time you have taken to answer these questions.

Please return the survey by January 15, 1999 in the enclosed envelope. Please include any documents relevant to your answers, including state policy guidance, regulations and outreach guides.

Please call Patricia Nemore at 202-289-6976 ext. 204 or e-mail at <tnemore@nsclc.org>
with any questions.

The person completing this survey:
Name _____
Agency _____
Address _____
_____
Phone_____Fax _____
e-mail_____

Please return it in the self-addressed envelope that was included with this survey or to

Patricia Nemore
Staff Attorney
National Senior Citizens Law Center
1101 14th Street, N.W., Suite 400
Washington, DC 20005

APPENDIX TWO:

Summary of Social Security Administration Buy-in Demonstration Project

QMB DEMONSTRATION PROJECT
NATIONAL PILOT SITES/MODELS

SCREENING PA	CO-LOCATION PA OK	APPLICATION KY IN TX FL	WIDOW(ERS) MA
Publicity 3/1 Mailings: 3/12, 4/06, 4/23, 5/14	Publicity 4/6 Mailings: 4/06, 4/23 5/14, 6/07 7/06	Publicity 4/23 Mailings: 4/23, 5/14, 6/07, 7/06	Target 4/15
			Boston (0030), Massachusetts (Suffolk County)
Perry & Cumberland Counties, Pennsylvania (Carlisle DO 0A35)	Fayette County, Pennsylvania (Uniontown DO 0212)	Fayette County Kentucky (Lexington DO 0439)	
Lebanon County, Pennsylvania (Lebanon DO 0240)	Chester County, Pennsylvania (West Chester DO 0237)	Vanderburgh County, Indiana (Evansville DO 0457)	
	Muskogee, Oklahoma (DOC 0787)	Nueces County, Texas (Corpus Christi DO 0825)	
	Oklahoma City (0783) Oklahoma (Oklahoma County)	Miami Central DO, Florida (DOC 0E99)	
		Orlando DO, Florida (DOC 0657)	

SSA Program Circular

General Series

Social Security Administration

No. 059-99-OPB **Date: March 12, 1999**

Office of Program Benefits
Division of Representative Payment and Evaluation

Demonstration to Improve Enrollment in State Buy-in to Medicare for Low-Income Medicare Beneficiaries

Introduction

In March 1999, SSA begins a demonstration with seven State partners to identify and overcome the obstacles to enrollment in the Medicare Part B buy-in programs. Congress has ordered this effort because of low enrollment in the Medicare Part B buy-in programs. **This demonstration affects all field offices (FOs), teleservice centers (TSCs) and SPIKES in the program service centers (PSCs) not just those involved in the demonstration. Your help is needed to make this effort a success.**

SSA TSCs and FOs not servicing a demonstration community should be sensitive to walk-ins and others inquiring about Medicare buy-in programs and should follow current procedures on page 6.

Destruction Date: December 31, 1999
Distribution: All holders of POMS Part 02, Chapter 009, Subchapter 03 and Part 06, Chapter 009, Subchapter 20 and TC, Part 17

Background

SSA's fiscal year (FY) 1999 appropriation contained $6 million for Federal-State partnerships to evaluate means to promote the

Medicare buy-in programs. The demonstration will target the following groups:

Qualified Medicare Beneficiaries (QMBs). QMBs are individuals who are eligible for Medicaid payment of their Medicare premiums, deductibles and coinsurance. QMBs must have Medicare Part A, or Health Insurance (HI) benefits (POMS HI 00801.140).

QMBs must also have income that does not exceed the Federal poverty level (FPL) after using the SSI income exclusions, and have resources with values that do not exceed twice the SSI standards after using the SSI resources exclusions.

Specified Low-income Medicare Beneficiaries (SLMBs). SLMBs are Medicare beneficiaries who would be QMBs but for income which exceeds the FPL but is less than 120 percent of the FPL after using the SSI income exclusions. SLMBs are eligible only for Medicare Part B buy-in.

Qualifying Individuals-1 (QI-1s). QI-1s are Medicare beneficiaries who would be QMBs or SLMBs but for income which exceeds the allowable limit but is less than 135 percent of the FPL after using the SSI income exclusions. QI-1s are eligible only for Medicare Part B buy-in, subject to available funding.

NOTE: SSA FOS are notified every year of the FPL-based monthly income ceiling for each of these programs.

SSA's demonstration will evaluate the level of awareness about the Medicare Part B buy-in programs, the confusion of potential eligibles as to how to apply for those programs and the belief that beneficiaries prefer dealing with SSA FOs rather than local Medicaid offices.

Demonstration Models to Screen for Potential Buy-in Eligibility, Refer to State Medicaid Agency for Determination or Assist with Application Taking

Demonstration Design

SSA began the buy-in demonstration on March 1, 1999 using four different test models and a unique toll-free number located in Baltimore, **1-877-772-7002.** A TTY/TDD number for the deaf and hearing impaired, **1-877-772-7003,** also will be available. Three of the models include special publicity efforts and test SSA buy-in eligibility screening, co-location of State workers taking buy-in applications and SSA buy-in application taking. The fourth model, targeting widow(er)s, will not involve special publicity.

For the first three models, SSA will analyze the master beneficiary record (MBR) by specified zip codes of beneficiaries who do not have buy-in and whose title II is below the QI-1 level. Each selected potential buy-in beneficiary will receive a letter from SSA requesting that the beneficiary contact SSA at the unique toll-free number located in Baltimore or contact the servicing FO or Medicaid State agency. When contacted, an SSA employee will discuss buy-in eligibility and use a personal computer (PC) based program designed for the demonstration to conduct a basic buy-in eligibility screening.

The PC program will determine residence in a test site. If the beneficiary resides in a test site, the outcome of the screening will result in an informational letter telling the beneficiary where to file an application. The demonstration will end on or before December 31, 1999.

Demonstration Models

Screening Model - This model will test the use of SSA as a "filter" for potential buy-in eligibility. If screening indicates potential buy-in eligibility, SSA will attempt to set up an appointment for an application with the Medicaid agency office servicing the beneficiary's community.

Screening Model Communities
Perry and Cumberland Counties, PA (Carlisle FO)
Lebanon County, PA (Lebanon FO)

Co-location Model - This model will test the use of an SSA (rather than State or county) office for buy-in eligibility application taking. If the beneficiary appears eligible based on the screening, SSA will set up an appointment for an application with a Medicaid agency employee located at an SSA office servicing the community.

Co-location Model Communities
Oklahoma County, OK (Oklahoma City FO)
Muskogee County, OK (Muskogee FO)

Chester County, PA (West Chester FO)
Fayette County, PA (Uniontown FO)

Application Model - This model will test State Medicaid agency buy-in applications completed by SSA employees. An SSA employee will complete the State's application form for buy-in, accept and copy any evidence provided at the time of the application, and forward the completed application form and evidence to the Medicaid agency

Application Model Communities
Dade County, FL (Miami Central FO)
Orange and Osceola Counties, FL (Orlando FO)
Vanderburgh County, IN (Evansville FO)
Fayette County, KY (Lexington FO)
Nueces County, TX (Corpus Christi FO)

Widow(er)s Model - This model will test intervention without extraordinary publicity. Beneficiaries in the Widow(er)s Model will not receive special mailings or special publicity from SSA about the Medicare buy-in programs. Instead, they will be screened for potential buy-in eligibility when they contact a designated SSA office to report the death of the spouse. SSA will set up an appointment with the Medicaid agency for potential eligibles to file for buy-in benefits.

Widow(er)s Model Communities
State of Massachusetts (all 30 FOs)

Impact

The SSA FOs servicing the demonstration communities will have special instructions.

Other SSA FOs can expect increased buy-in traffic as well. Although the demonstration project will use a unique toll-free number, the increased publicity and public attention may produce phone and walk-in inquiries at all SSA FOs and phone inquiries to the national 800 number.

For the Co-location and Application model sites, the PE appointment system, calendar 3 will be used to schedule QMB appointments. Appointments should be scheduled only by the special screening unit or by offices participating in the QMB demonstration project. These calendars will be specially marked QMB only and should not be used by other FOs, TSCs or PSCs to schedule appointments.

We expect that people who do not live in the demonstration area

will contact the unique and regular toll-free numbers and local numbers in response to publicity. Also, SSA will send letters to people requesting that they call the unique toll-free number based on the MBR mailing address, but their participation in the demonstration project will be based on their residence address. If you receive inquiries from individuals and you are not a demonstration FO, follow the current procedures described below.

Employees at the unique toll-free number will have limited ability to process persons who reside outside of the test sites and may refer them to the national 800 number or servicing FO for help. These employees will not be able to process cases where an individual does not have Medicare Part A.

Mailings to demonstration sites will be staggered by terminal Social Security Number digit over four months. Expect a surge in inquiries shortly after each of the following mailing dates:

MODEL	Mar. 12	Apr. 6	Apr. 23	May 14	June 7	July 6
Screening	X	X	X	X		
Co-location		X	X	X	X	X
Application			X	X	X	X

<u>Current Procedures</u>

The Teleservice Center Operating Guide (TSCOG), Medicaid Chapter, is an excellent source of information about Medicaid referral activities. Written for SSA's 800 number inquiries, it can be adapted for FO use. It is available on CD-ROM under POMS TC. *SSA Program Circular* No. 01-98-OPB--General Series also provides information on State programs that help beneficiaries with Medicare premiums and/or expenses.

If your office is not a test site and you receive an inquiry about the buy-in programs, first consider potential SSI eligibility. If not SSI eligible, consider whether the beneficiary might qualify for help from one of the buy-in programs; QMB, SLMB, QIs and Qualified Disabled Working Individuals (QDWIs). QDWIs are individuals enrolled in Premium HI for the Working Disabled who meet the requirements in

POMS SI 01715.005. States are required to pay HI but not SMI premiums for QDWIs.

If an individual is eligible for SSI and resides in a 209b State, consider if they qualify for any of the buy-in programs and refer them to the State.

Follow the instructions in POMS HI 00801 (Hospital Insurance Entitlement) to determine if an individual has, or can get, Part A. Also consider the referrals for other possible categories of Medicaid eligibility and referrals for other help that may be available.

Refer beneficiaries who appear eligible for any of the Medicaid programs to the local Medicaid or social services office. You may need to help a beneficiary contact other agencies if he/she appears unable to act effectively.

Please note that the TSCOG contains the 1998 buy-in income limits. Shortly, you should receive notice of the 1999 income limits for Medicaid programs which become effective April 1, 1999.

Conclusion

SSA's role in the Medicare Part B buy-in process is under close observation not just in the demonstration sites, but throughout the nation. Your sensitivity to potential buy-in eligibles will contribute much towards SSA's success in this effort.

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