Memorandum

To: **All Members**

From: **ADvancing States**

Re: **Streamlining Medicaid; Medicare Savings Programs Eligibility Determination and Enrollment**

Date: **November 3, 2023**

On September 21 2023, Centers for Medicare & Medicaid Services (CMS) published the final Streamlining Medicaid; Medicare Savings Programs Eligibility Determination and Enrollment Rule. The final rule reduces administrative barriers and simplifies Medicare Savings Program (MSP) enrollment, helping millions of older adults and people with disabilities afford Medicare coverage. The purpose of the summary is to bring awareness to the final regulation.

MSPs, run by state Medicaid programs, cover Medicare premiums and, in most cases, cost-sharing for more than 10 million older adults and people with disabilities who have limited incomes. Only about half of eligible people are currently enrolled, in part due to cumbersome application and verification processes.

The final rule codifies provisions from the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and builds upon its requirements to further streamline MSP enrollment for Low-Income Subsidy (LIS) enrollees and address persistent under enrollment in the MSPs. CMS estimates implementation of the final rule will increase MSP participation by 860,000 people. CMS also estimates the final rule will save older adults and people with disabilities nearly 19 million hours in paperwork each year and reduce state administrative burden by over two million hours annually.

The final rule is effective November 17, 2023. However, implementation dates of the provisions vary, with provisions requiring states to automatically enroll Supplemental Security Income (SSI) recipients as Qualified Medicare Beneficiaries (QMBs) starting in October 2024 and all other provisions requiring compliance by April 2026. CMS intends to provide technical assistance to states with the policy requirements.

The full text of the final rule can be found here:
https://www.federalregister.gov/documents/2023/09/21/2023-20382/streamlining-medicaid-medicare-savings-program-eligibility-determination-and-enrollment

Background: Low-Income Subsidy Program ("Extra Help")

MIPPA requires states to streamline enrollment of Medicare Part D LIS program enrollees into the MSPs. The Medicare Part D LIS program, also referred to as "Extra Help," is administered by the Social Security Administration (SSA) and pays Medicare Part D prescription drug premiums and cost-sharing for over 13 million individuals with low incomes.

Most LIS enrollees are deemed eligible for LIS by virtue of their enrollment in Medicaid. Others apply by completing an application and submitting it to SSA. SSA uses the application information to determine LIS eligibility. Section 113 of MIPPA requires SSA to transmit data from LIS applications ("leads data") to state Medicaid agencies and requires that the electronic transmission from SSA "shall initiate" an MSP application. MIPPA also requires states to accept leads data and "act upon such data in the same manner and in accordance with the same deadlines as if the data constituted" an MSP application submitted by the individual. Despite these statutory requirements, not all states initiate an MSP application upon receipt of leads data from SSA.

Key Provisions of the Final Rule

- Better leverages the Low-Income Subsidy (LIS) program to enroll eligible individuals in the MSPs, including maximizing use of LIS "leads" data and defining "family of the size involved" for MSP groups to be no less than the definition of "family size" in the LIS program.
- Reduces the burden on MSP applicants to produce certain types of documentation prior to enrollment.
- Automatically enrolls certain Supplemental Security Income (SSI) beneficiaries into the Qualified Medicare Beneficiary (QMB) MSP group.
- Ensures the earliest possible effective date of QMB coverage for individuals who must pay a premium to enroll in Part A and reside in certain states.

Provisions from Proposed Rule Not Addressed in Final Rule

The rule finalizes the MSP-related provisions from the CMS notice of proposed rulemaking, published on September 7, 2022, which included several proposed eligibility, enrollment, and renewals changes for Medicaid and CHIP. CMS plans to address the remaining provisions and public comments from the proposed rule in subsequent rulemaking.

Provisions not addressed in this final rule:

- Aligning renewal processes for non-Modified Adjusted Gross Income (MAGI) groups (including MSPs) with the MAGI eligibility groups;
- Allowing medically needy individuals to deduct prospective HCBS medical expenses; and
- Removing the requirement for individuals to apply for other benefits.

Summary of Final Rule Provisions

Facilitating Medicaid Enrollment through Part D LIS "Leads" Data (42 CFR §§ 435.4, 435.601, 435.911, and 435.952)

- States must accept, via secure electronic interface, the SSA LIS leads data and must treat the leads data as an application for the MSPs, without requiring individuals to submit a separate application.
- States must accept information provided through the leads data relating to a criterion of eligibility without further verification. States must refrain from requesting information from individuals already provided through leads data, unless information available to states (1) is not reasonably compatible with information provided by or on behalf of the individual or (2) the information provided through the leads data does not support an eligibility determination.
- States must seek additional information as needed to determine MSP eligibility, such as citizenship or immigration status.
- States must promptly determine MSP eligibility. States may use either the date that LIS data is received from SSA or the date that an individual LIS application is submitted as the start of the calculation of the 45-day processing timeline.
- In addition to and separate from any requests for additional information necessary for the determination of MSP eligibility, states must provide to individuals effectively applying for the MSPs through an LIS application:
    1) Information about the availability of Medicaid benefits on other bases, including the scope of benefits and responsibilities of the individual applying for such benefits; and
    2) An opportunity to furnish additional information needed to determine whether the individual is eligible for additional Medicaid benefits.
- States may request CMS approval of another approach to ensure applicants have the opportunity to receive determinations on their eligibility for Medicaid benefits other than through an MSP.

States must come into compliance with these requirements by **April 1, 2026**.

Streamlining Verification for Eligibility Requirements (42 CFR § 435.952)

In determining MSP eligibility, most states utilize methodologies similar to the SSI program, such as using interest and dividends, non-liquid resources, burial funds, whole life insurance and in-kind support and maintenance which are not considered with a LIS application. However, states have the option to align their MSP eligibility methodologies with that of LIS, and some states disregard otherwise-countable income and/or resources. For example, several states and the District of Columbia have eliminated the asset test for MSPs, while others have raised the asset limit to $10,000 or more for life insurance policies.

To simplify enrollment processes for eligible individuals, the final rule requires states to adopt several simplification policies related to the income and resources that are counted in determining MSP eligibility. These policies are intended to enable state agencies to use the leads data more efficiently, reduce burden on applicants and states, and increase the number of LIS enrollees successfully enrolled in the MSPs.

Under 42 CFR § 435.952, states must accept self-attestation without further information for certain MSP eligibility criteria:

- Interest and dividend income;
- Non-liquid resources, burial funds; and
- Face value of whole life insurance policies.

Self-attestation for MSP eligibility determinations applies to both MSP applications submitted directly through the states or indirectly through the LIS program.

- For burial funds, states must allow individuals to self-attest that up to $1,500 of their resources, and up to $1,500 of their spouse's resources, are set aside as burial funds in a separate account, and therefore, are not countable as resources for MSP eligibility determinations.
- For life insurance policies, if the total face value of an individual's life insurance policies does not exceed $1,500, the cash surrender value of the individual's policies is not counted in determining MSP eligibility. (Note: Term life insurance is not impacted by this rule.)
- States cannot request documentation of dividend and interest income, non-liquid resources, burial funds, and life insurance policies prior to determining MSP eligibility, except when the agency has information that is not reasonably compatible with the applicant's attestation.
- For interest and dividend income, non-liquid resources, burial funds, and life insurance policies, states retain the option to verify such income after the individual has been enrolled. This process is called "post-enrollment verification," which is currently available to states with respect to most eligibility criteria. States also have the option to require the individual to provide documentation of interest and dividend income, non-liquid resources, and life insurance policies if electronic verification is not available.
- If a state chooses to conduct post-enrollment verification checks for an individual's interest and dividend income, non-liquid resources, burial funds, and/or life insurance policies, it must allow individuals at least 90 calendar days to respond to requests for documentation. When documentation of the cash surrender value of a life insurance policy is required, the state must assist the individual with obtaining this documentation by requesting that the individual provide the name of the insurance company and policy. The state must allow the individual at least 15 calendar days to provide such documentation if required (that is, if documentation of the cash surrender value is needed prior to the agency's determination of eligibility) and at least 90 calendar days if required post-enrollment.

- If a state found that an individual has income or resources exceeding the standard during the post-enrollment verification process, the state would take appropriate action consistent with current regulations. Appropriate action includes determining eligibility on other potential bases and, if not eligible on any basis, providing advance notice and fair hearing rights prior to terminating MSP coverage.

States are required to come into compliance with these policies by April 1, 2026.

Definition of Family Size (42 CFR § 435.601)

- For purposes of determining eligibility for the MSP groups, "family of the size involved" is defined to include at least the individuals included in the definition of "family size" in the LIS program. The LIS program definition of "family size" includes the applicant, the applicant's spouse (if living with the applicant), and "[a]ny persons who are related by blood, marriage, or adoption, who are living with the applicant and spouse and who are dependent on the applicant or spouse for at least one half of their financial support" (42 CFR § 423.772).
- States would retain flexibility to include other individuals who are not described in the LIS definition. Additionally, this proposal would not affect states' ability to adopt a different reasonable definition of the phrase for purposes of other eligibility groups.

States are required to come into compliance with these requirements by **April 1, 2026**.

Automatically Enroll Certain SSI recipients into QMB MSP Group (42 CFR § 435.909)

- States must automatically enroll individuals eligible for Medicare Part A and who are SSI beneficiaries in QMB-MSP without needing an application. CMS newly requires that:
    1) States with 1634 agreements must deem SSI recipients eligible for QMB coverage who are entitled to premium-free Medicare Part A;
    2) States without 1634 agreements must deem SSI recipients eligible for QMB coverage who are entitled to premium-free Medicare Part A and have been determined eligible for Medicaid under either 42 CFR § 435.120 or § 435.121; and
    3) Part A buy-in states must deem individuals eligible for QMB coverage if the individual is determined eligible for Medicaid under either 42 CFR § 435.120 or § 435.121, entitled to SSI, only qualifies for premium-Part A, and is enrolled in Part B.
        - Throughout the year, Part A buy-in states can automatically enroll SSI recipients in QMB and enroll individuals in Part A, whereas individuals in Part A group payer states can only enroll in premium-Part A during the annual General Enrollment

Period (January through March) if they missed their Initial Enrollment Period and missed or do not have a Special Enrollment Period.

- CMS will permit (not require) group payer states to deem SSI recipients without premium-free Part A eligible for QMB by employing processes used by Part A buy-in states to initiate Part A enrollment without requiring the individual to apply for conditional Part At. Under this proposed state option, once the state has determined the individual eligible for the mandatory SSI or 209(b) group and becomes liable for paying their Part B premiums under the buy-in agreement pursuant to § 407.42, the state would also be able to deem them eligible for the QMB group.
- To implement these new requirements, states will need to identify Medicare-eligible SSI recipients to enroll them in the MSPs. States will also need to t make eligibility systems changes to enable QMB enrollment once the SSI-individual is Medicare eligible. Current regulations do not allow state Medicaid agencies to forgo an eligibility determination for Medicaid beneficiaries who are eligible for SSI when they become newly eligible for Medicare Parts A and B. Therefore, this new requirement will require system changes for all 51 states and Washington, D.C.
- CMS may consider later whether a basis exists to streamline QMB enrollment for non-SSI recipients who lack premium-free Part A in future rulemaking. CMS is available to explore with states options to streamline their current QMB eligibility and enrollment processes for this population.

States are required to come into compliance with these requirements by **October 1, 2024**.

QMB effective date for individuals who have a Part A premium, reside in a group payer state, and enroll in conditional Part A during the General Enrollment Period (42 CFR § 406.21)

- CMS will codify existing policy that individuals who reside in group payer states and enroll in actual or conditional Part A during the General Enrollment Period can obtain QMB as early as the month Part A entitlement begins.
- CMS will incorporate in regulations their practice of providing states with Federal matching funds or FFP for paying an individual's Part A premium the first month of entitlement.

States compliance deadline is **April 1, 2026**.

Appendix: Key Terms

Term	Description/Description
Medically Needy	Frequently referred to as "spend down" programs, medically needy eligibility categories allow individuals with income above the standard Medicaid limits to become eligible once they spend a sufficient amount on eligible medical expenses. In other words, the individual must spend down their income to a state-defined threshold to become Medicaid eligible.
Modified Adjusted Gross Income (MAGI)	A standardized way of counting income, based on the Internal Revenue Service (IRS) adjusted gross income calculations. These calculations are applied to eligibility categories that are not based upon an individual having a disability or being over age 65. MAGI groups are generally considered to comprise eligibility categories for children, pregnant women, parents and caretaker relatives, and childless adults aged 19-64 (i.e., the Affordable Care Act expansion). These groups are not specifically for older adults and people with disabilities; however, there are instances where individuals in those populations may be enrolled in MAGI groups.
Non-MAGI groups	In contrast to MAGI-based groups, non-MAGI groups are eligibility categories that are based on an individual having a disability and/or being an older adult. These groups do not use the MAGI standard and income calculations are usually (but not always) based on SSI program methodology. Unlike MAGI groups, asset tests may be applied to non-MAGI groups. Non-MAGI groups also provide options for states to apply disregards that may alter the statutory income or asset requirements. Because the statute describes these groups as focused on "aged, blind, or disabled" individuals, they are frequently referred to as ABD groups.
Medicare Savings Programs (MSPs) (link)	A group of eligibility categories that allow Medicaid to pay for Medicare premiums, and in some cases, some or all Medicare out-of-pocket costs.
Low Income Subsidy (LIS) Program	This program reduces out-of-pocket expenses in the Medicare Part D program for certain low-income individuals. The Social Security Administration (SSA) verifies eligibility for this program and submits data to states each day on eligible individuals (with the individuals' consent). This information, frequently referred to as leads data, includes information on the

	individual's address, income, resources and household size, all of which has been verified by SSA.
Supplemental Security Income (SSI) (link)	SSI provides monthly payments to people with disabilities and older adults who have little or no income or resources. Medicaid eligibility for individuals 65 and older or who have blindness or a disability is generally determined using the income methodologies of the SSI program administered by the SSA. • States that request SSA to make Medicaid eligibility determinations for SSI recipients are known as "1634" states (33 states and the District of Columbia); • "SSI criteria states" use SSI eligibility criteria for Medicaid eligibility and may make their own Medicaid determinations (nine states); and • "209(b) states" use at least one eligibility criterion more restrictive than the SSI program and require SSI recipients to complete a Medicaid application (eight states). Additionally, many SSI recipients typically qualify for other federal and state programs, including Medicare under 42 CFR § 406.5(a) and (b).