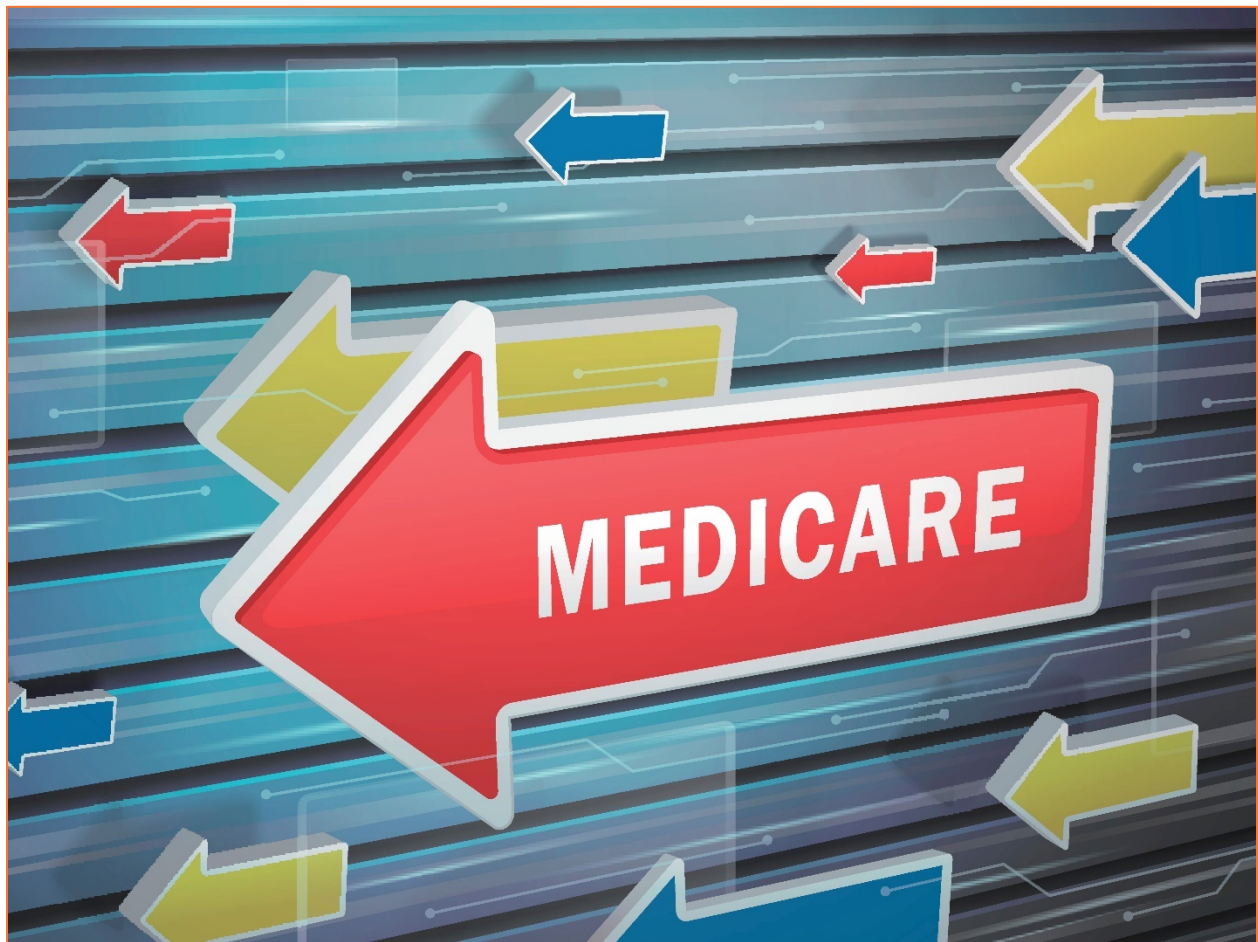# Toward Seamless Coverage

Identifying Enrollment Gaps and Opportunities in Medicare Transitions for People with Expansion Medicaid

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EXECUTIVE SUMMARY

The Affordable Care Act (ACA) gives states the option to expand their Medicaid programs, and 32 states including the District of Columbia have decided to do so. This expansion has extended Medicaid coverage to low-income adults aged 19-64 with incomes up to 138% of the federal poverty level (FPL), through what is referred to as the "Adult Group." A challenge for this population is that they are not permitted to have both Medicare and Medicaid, so expansion Medicaid eligibility ends when an individual reaches 65 or is otherwise Medicare-eligible.

Once Medicare-eligible, an individual with Adult Group Medicaid typically will enroll in Medicare and can transition—if their income and assets are low enough—to traditional Medicaid for the aged, blind, and disabled population (ABD Medicaid) or a Medicare Savings Program (MSP). Income and asset rules for Adult Group Medicaid are usually less stringent than income and asset rules for traditional Medicaid programs, so people newly eligible for Medicare can face the "Medicaid cliff," where they discover that they are no longer eligible for Adult Group Medicaid and are also not eligible for ABD Medicaid, meaning their out-of-pocket health care costs are significantly higher, and potentially unaffordable. This circumstance makes it especially important to ensure that any transitioning individual who is ineligible for ABD Medicaid is screened for and enrolled in an MSP as soon as possible.

In order to better understand the challenges and promising practices inherent in transitions from Adult Group Medicaid to Medicare and other forms of assistance, the Medicare Rights Center—with support from the National Council on Aging (NCOA) under its Medicare Improvements for Patients and Providers Act (MIPPA) contract—completed an extensive review of Adult Group Medicaid-to-Medicare transition processes in states that have expanded Medicaid. This included exploring MSP screening and enrollment processes in expansion and select non-expansion states.

Drawing on months of interviews with targeted states, Medicare Rights identified three key parts of the Adult Group Medicaid-to-Medicare transition process, each with its own state-specific promising practices and challenges:

1. Identification of Adult Group beneficiaries transitioning to Medicare
2. Beneficiary communications
3. Determinations and redeterminations for ABD Medicaid and MSP eligibility

Based on Medicare Rights' findings, there are many opportunities for states to learn from each other and improve processes. This includes identifying individuals transitioning from Adult Group Medicaid to Medicare, educating them about needed benefits, and screening and enrolling them appropriately. This paper aims to highlight promising state-specific practices that other states might adopt, as well as hurdles that states will work through in their own ways, seeking the most seamless coverage possible for lower-income older adults and people with disabilities.

INTRODUCTION

The Affordable Care Act (ACA) gives states the option to expand their Medicaid programs to cover low-income adults who are not eligible for Medicare and who have annual incomes below 138% of the federal poverty level (FPL)—$16,643 in 2017 for an individual.[1] To date, 32 states including the District of Columbia have decided to cover this population, called the "Adult Group."[2] Adult Group Medicaid differs in key ways from other forms of Medicaid, creating special considerations and transition issues for this population when they approach Medicare eligibility.

Terminology

Medicaid: A health insurance program for people with low incomes funded with a combination of state and federal funds. Currently, Medicaid provides coverage for over 70 million Americans. Most people with Medicaid do not pay premiums, copayments, or coinsurance for covered benefits. The Medicaid statute requires coverage of mandatory groups, while states may choose to cover other groups.

- Medicaid's **Aged, Blind, and Disabled (ABD) group:** A mandatory group covering people who are over 65, blind, or have a disability, and who meet financial requirements. Importantly, the ABD population can be concurrently enrolled in both Medicare and Medicaid.

- Medicaid's **Adult Group:** An optional group, often called expansion or expanded Medicaid. To be eligible, an individual must be aged 19-64, have an income below 138% of the FPL, and not be eligible for Medicare. There is no asset limit for Adult Group Medicaid.

Medicare Savings Programs (MSPs): Several programs funded through a combination of state and federal dollars and administered by states to help low-income people with Medicare afford Medicare Part B premiums and, depending on the program, other Medicare cost-sharing. The MSPs are the **Qualified Medicare Beneficiary (QMB)** program, the **Specified Low-Income Beneficiary (SLMB),** and the **Qualified Individual (QI)** program.

- **Qualified Medicare Beneficiary (QMB) program:** The only MSP that pays Medicare for cost-sharing (e.g., copayments and coinsurance), in addition to covering Part B premiums. QMB is available to beneficiaries with incomes up to 100% of the FPL, and states can choose to increase this limit. QMB may also have an asset limit, though states can choose not to count assets when determining QMB eligibility.

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[1] HealthCare.Gov, "See if your income falls in the range to save" (last visited August 7, 2017), *available at* https://www.healthcare.gov/lower-costs/.

[2] We will refer to individuals eligible for expansion Medicaid as those in Adult Group Medicaid. For most of these states, coverage of Adult Group Medicaid began January 1, 2014. Seven states joined the expansion program after that date.

State Health Insurance Assistance Programs (SHIPs): Each state and territory offers a SHIP, partly funded by the federal government, to provide free counseling and assistance. The 54 SHIPs help people learn about Medicare plan options, understand Medicare communications, appeal coverage denials, apply for programs that help save costs, and learn about and contact other agencies for additional assistance. Go to https://www.shiptacenter.org/ to find your SHIP.

Individuals with Adult Group Medicaid lose their eligibility for the program when they become Medicare-eligible.[3] These individuals should be screened for both Aged, Blind, and Disabled (ABD) Medicaid and Medicare Savings Program (MSP) eligibility. But because Adult Group Medicaid eligibility requirements are less stringent than those for ABD Medicaid, many Adult Group Medicaid recipients find that when they lose this form of Medicaid owing to Medicare eligibility they are also not eligible for ABD Medicaid. These individuals have reached what is referred to as the "Medicaid cliff," a point at which a beneficiary's out-of-pocket costs can become significantly higher than their costs under Adult Group Medicaid—and when receiving other forms of assistance—such as an MSP—becomes all the more important.

Income and asset rules for ABD Medicaid are more stringent than income and asset rules for Adult Group Medicaid in two ways: 1) ABD Medicaid's income eligibility is below 100% of the FPL in all states—below 75% in most—which is considerably lower than the 138% of the FPL limit for Adult Group Medicaid;[4] and 2) ABD Medicaid in most states includes a strict asset limit, while there is no asset limit for Adult Group Medicaid. This eligibility disparity means many people with Adult Group Medicaid coverage find themselves ineligible for ABD Medicaid coverage.

Importantly, MSPs are a possible recourse for some of these beneficiaries.[5] MSP income and asset limits are higher than ABD Medicaid limits, and some states have eliminated MSP asset limits entirely.[6] This makes it vital that states effectively screen the Adult Group-to-Medicare transitioning population effectively, to help them avoid the Medicaid cliff as often as possible.

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[3] 42 U.S.C. 1396a(10)(A)(VII).

[4] Molly O'Malley Watts, Elizabeth Cornachione, & MaryBeth Musumeci, "Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015" (March 1, 2016), *available at* http://www.kff.org/report-section/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-in-2015-report/.

[5] The Low-Income Subsidy (LIS)—also known as "Extra Help"—also provides valuable assistance for people with Medicare to afford their Medicare Part D prescription drug costs. If an individual is eligible for and MSP, they are automatically eligible for LIS, which is administered by the Social Security Administration. This makes effective transitions to MSPs doubly powerful. For more information on LIS, *see, e.g.* Medicare Interactive, "Extra Help: Assistance paying for the Medicare drug benefit" (last visited August 17, 2017), *available at* https://www.medicareinteractive.org/get-answers/programs-for-people-with-limited-income/the-extra-help-program/extra-help-assistance-paying-for-the-medicare-drug-benefit.

[6] National Council on Aging's Center for Benefits Access, "Medicare Savings Programs (MSPs): Eligibility and Coverage (2017)" (March 2017), *available at* https://www.ncoa.org/wp-content/uploads/medicare-savings-programs-coverage-and-eligibility.pdf.

Jean is 64 years old and has health coverage through Adult Group Medicaid in Illinois. She has an income of $13,000/year, which is approximately 110% of the FPL, and non-exempt assets totaling $9,000. (Remember, assets are not counted when determining an individual's Adult Group eligibility.)

In Illinois, the maximum income to qualify for ABD Medicaid is 100% of the FPL, and the maximum allowable non-exempt asset level is $2,000. Thus when Jean reaches age 65, she will be ineligible for ABD Medicaid.

Jean's income is also too high for the most generous MSP—the Qualified Medicare Beneficiary program—which would pay her Medicare Part B premiums and cost-sharing. While her income is not too high for another MSP—the Specified Low-Income Medicare Beneficiary (SLMB) program—the limits for which go up to 120% of the FPL—that program limits assets to $7,280, so Jean's assets are too high to qualify.

If, instead of Illinois, Jean lived in Arizona, a state that has waived the asset limit for MSPs, she would be eligible for SLMB. Through SLMB, Medicaid would pay for Jean's Part B premiums.

While most transitions from Adult Group Medicaid to Medicare are a result of the person aging into Medicare (i.e. turning 65), there is another path: approval for Social Security Disability Insurance (SSDI) allows a person under age 65 to access Medicare benefits. SSDI immediately begins paying cash benefits for those who are eligible, but it requires a 24-month waiting period before Medicare eligibility begins. As this report will reveal, this group is the most difficult to identify and help transition effectively from Adult Group Medicaid to Medicare.

Whether an individual is transitioning to Medicare based on age or disability, many will face higher out-of-pocket health care costs when no longer eligible for Adult Group Medicaid, unless they are found eligible for and properly enrolled in ABD Medicaid or an MSP. This paper will explore the many promising practices and challenges that the Medicare Rights Center found in states working to identify the transitioning population, communicate with them, and screen and enroll them in needed benefits wherever possible.

METHODOLOGY

Over the course of several months (January through June 2017), the Medicare Rights Center—with support from the National Council on Aging (NCOA) through its Medicare Improvements for Patients and Providers Act (MIPPA) contract—conducted a survey of professionals in Medicaid expansion states and select non-expansion states. The purpose of the survey was to gather information about states' existing policies and practices for managing the transition of Adult
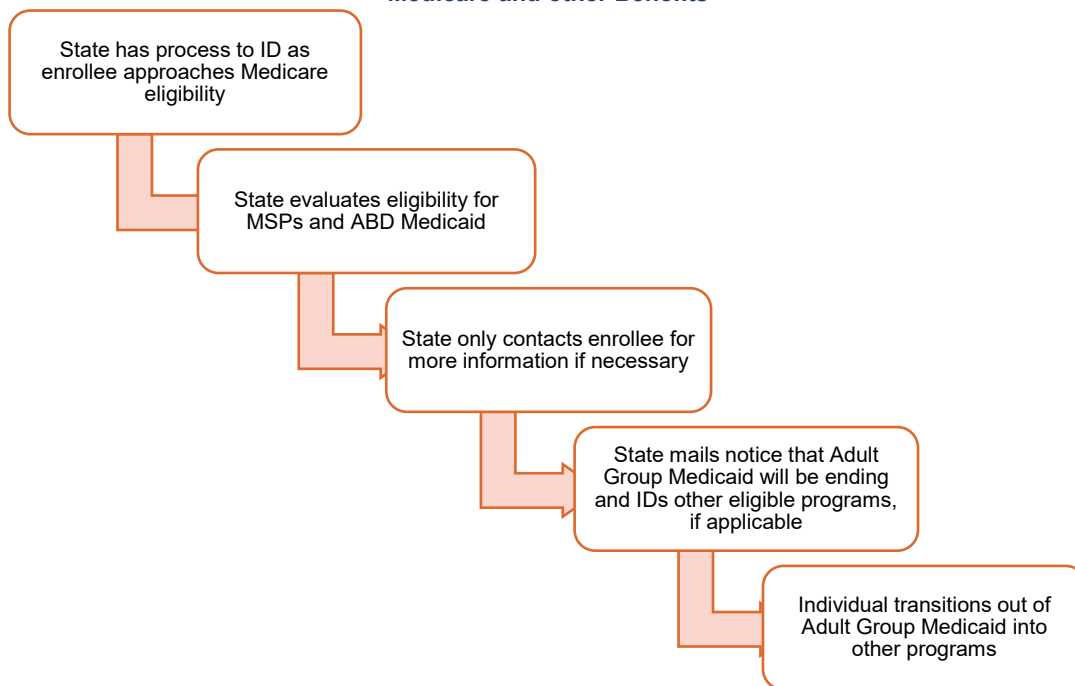
Group Medicaid recipients to Medicare, ABD Medicaid, and MSPs.[7] Medicare Rights assessed survey results, identified potential promising practices and challenges, and then contacted survey respondents for in-depth interviews regarding transition issues. Ultimately, 22 states responded, accounting for 68% of the 32 states with Adult Group Medicaid programs.

Findings: Promising Practices and Challenges Related To Transitions From Adult Group Medicaid To Medicare

Based on Medicare Rights' survey findings, there are many opportunities for states to learn from each other and improve processes for identifying individuals transitioning from Adult Group Medicaid to Medicare, educating them about needed benefits, and enrolling them appropriately. Each of the identified promising practices and challenges were reported by at least one state.

Medicare Rights' survey findings also indicate that there is significant variation in how states facilitate transitions from Adult Group Medicaid to Medicare and other benefits, including ABD Medicaid and MSPs. Before delving into the steps through which transitioning individuals are identified, educated, and screened for and enrolled in benefits, it may be useful to consider an ideal transition process, specifically one that reduces beneficiary and administrative burden, enrollment delays, and mistakes.

Figure 1: Ideal Process Map for Transitioning Adult Group Medicaid Recipients to Medicare and other Benefits

State has process to ID as enrollee approaches Medicare eligibility

State evaluates eligibility for MSPs and ABD Medicaid

State only contacts enrollee for more information if necessary

State mails notice that Adult Group Medicaid will be ending and IDs other eligible programs, if applicable

Individual transitions out of Adult Group Medicaid into other programs

It is important to note that states may have good processes in place to identify, notify, and enroll beneficiaries but may not perfectly execute those processes. States also differ in their ability to

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[7] *See* Appendix.

provide effective transition assistance due to legacy systems, budgetary and staffing issues, program differences, and population issues.

Through the survey process, Medicare Rights identified three major themes in Adult Group Medicaid-to-Medicare transition processes, each with its own state-specific promising practices and challenges:

1. Identification of Adult Group Medicaid beneficiaries transitioning to Medicare
2. Beneficiary communications
3. Determinations and redeterminations for ABD Medicaid and MSP eligibility

I. Identification of Adult Group Medicaid beneficiaries transitioning to Medicare

Based on survey results, it is clear that states are more adept at identifying those who are no longer eligible for a Medicaid program because of income or assets than they are at identifying the rolling target of individuals who are aging into Medicare eligibility. States struggle to an even greater degree to identify those who are becoming Medicare eligible due to disability.

According to analysis of survey findings, systems issues are largely at fault for existing shortcomings related to the timely identification of aging-in and SSDI populations approaching Medicare eligibility. In some states, this is because information about an individual's coverage is split among multiple systems. Other states' systems lack data: For example, many states have no method to access data on SSDI recipients in their states, which means they have no way to identify those individuals who have completed their required 24-month waiting period and will be enrolled in Medicare.

The above barriers to seamless transitions can be exacerbated by limited state staffing and funding, limited development of processes, and a lack of training on programs and the transition process.

Promising practices

- Identify individuals approaching Medicare eligibility as early as possible. The Center for Medicare & Medicaid Services (CMS) suggests that "implementing processes to identify [transitioning] individuals early will help [states] to complete a redetermination of eligibility under other eligibility groups in advance of the start of Medicare eligibility."[8] Several states, including New York and Washington, take steps to make good on this suggestion. For instance, New York sends Adult Group Medicaid recipients a letter three

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[8] Centers for Medicare & Medicaid Services, "CMCS Informational Bulletin: Strategies to Streamline Transitions for Medicaid eligible Beneficiaries Who Newly Qualify for Medicare" (June 7, 2017), *available at* https://www.medicaid.gov/federal-policy-guidance/downloads/cib060717.pdf.

months before they turn 65; the letter explains the Medicare enrollment process and also provides instructions for how individuals can qualify for ABD Medicaid and an MSP. The process for sending the notice is fairly simple for the state, which has contact information and other data for its Medicaid recipients, including when they will reach the age of Medicare eligibility.

- Provide pre-notice assessment of eligibility. The vast majority of states start the transition process by identifying beneficiaries approaching Medicare eligibility and *then* notifying them of their upcoming termination from Adult Group Medicaid. However, Louisiana goes farther: The state identifies Medicare-eligible individuals and then conducts an eligibility assessment *before* notifying them. Louisiana uses data-matching that allows the state to make preliminary determinations about ABD Medicaid and MSPs in the majority of instances. The state then sends a notice to individuals alerting them not only of the termination of their Adult Group Medicaid, but also of their potential eligibility for other programs. This greatly reduces burden and stress for the individual, who usually does not have to take any action. In some circumstances, the individual may have to provide asset information, but the state actively requests this information if needed, instead of relying on the individual to volunteer the information.

Challenges

- Systems issues. IT systems that cannot share data or otherwise communicate have caused identification issues in many states.[9] Old systems that have not been updated often are unable to capture all beneficiary coverage data or share it efficiently. At the same time, as new systems are put in place, there can be a significant period of turmoil, lost information, dropped beneficiaries, untimely notices, and other problems. But these do not have to be permanent. In Michigan, for example, significant progress seems to have been made in improving a recently adopted computer system after several years of struggle to adapt it to the state's Medicaid program.

- Identifying Medicare eligibility due to disability. While aging into Medicare eligibility follows a set timeline, and a person's age is usually part of their record, the timeline for individuals to complete their 24-month SSDI waiting period is completely individual, based on the initial date of SSDI approval. This means the date they will become Medicare-eligible is less obvious, even to the beneficiary. Importantly, when such an individual is enrolled in Part B but declines the benefit, possibly because they think they can retain Medicaid, they may have to pay significant late enrollment penalties or

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[9] For more information on IT issues affecting MSP enrollment, s*ee, e.g.* Doug Goggin-Callahan, "Lessons from New York: Building a Better Medicaid Eligibility and Enrollment System for Duals," Medicare Rights Center (September 2012), *available at* http://nyshealthfoundation.org/uploads/resources/lessons-from-new-york-building-a-better-medicaid-eligibility-and-enrollment-system-for-duals.pdf.

experience gaps in outpatient coverage.[10] New York is using a new process to identify this population, using data from CMS, but it continues to be a challenge in many states.

- <u>Staffing and training.</u> When state employees are unclear about the basics of certain programs, they are unable to troubleshoot even obvious mistakes in the system. Well-trained employees are the first defense against systems glitches, typos, and data entry mistakes, or beneficiary errors such as submitting the wrong application or checking the wrong box. Employees are also in an ideal position to offer suggestions for improving notices, applications, and program design to address the problems they see in the field. Medicare Rights operates a national toll-free helpline and often hears from Medicare beneficiaries who experience a great deal of confusion as they attempt to navigate the Medicaid and MSP eligibility determination processes in their state. These individuals call Medicare Rights because, in many instances, they received conflicting or confusing information from state or federal workers. Survey results also indicated that state workers do not always have a clear understanding of how processes in their state work, either ideally or in practice. Staff turnover likely contributes to this problem, as some states struggle to retain trained, experienced employees.

II. Beneficiary communications

States are required to provide "timely and adequate" notice to all individuals of any decision or change affecting their Medicaid benefits.[11] The notice must be written in plain language, and be accessible for those with limited English proficiency and/or disabilities.[12] In developing the survey instrument that informed this report, Medicare Rights operated under the assumption that all states currently meet this legal requirement to provide adequate notice to individuals at the end of their Adult Group Medicaid eligibility. Survey results indicate, however, that developing and delivering these notices is not without challenge.

Even states that notify individuals in a timely fashion may use notices that lack necessary information, have errors, or are generally unclear. For instance, a particularly worrisome finding of Medicare Rights' survey is that many states do not include any information about MSPs in or with their notices about termination of Adult Group Medicaid. This oversight may contribute to high percentages of people in certain states being unaware of MSPs, leading individuals to needlessly delay applying for MSPs and related help, or failing to apply altogether. In addition, several states require several rounds of mailings, which in turn can delay eligibility

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[10] In 2014, about 750,000 Part B enrollees paid a late enrollment penalty because they mistakenly refused Part B coverage. *See* Patricia A. Davis, "Medicare: Part B Premiums," Congressional Research Service (August 4, 2016), *available at* https://fas.org/sgp/crs/misc/R40082.pdf.
[11] Goldberg v. Kelly, 397 U.S. 254 (1970). For more information regarding what notice is considered adequate in the Medicaid program, *see, e.g.*, Medicaid and CHIP Learning Collaboratives "Eligibility-related Determination Notices State Toolkit, Tool #1: Statutory and Regulatory Review" (August 27, 2013), *available at* https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/learning-collaborative-state-toolbox/downloads/tool-1-notices-statutory-and-regulatory-review.pdf.
[12] 42 CFR § 435.917.

determinations and enrollment. In states where notices are poorly written, designed, or timed, there can be confusion among notice recipients, increased administrative burdens for consumers and state workers, and penalties and coverage gaps for eligible individuals. On the other hand, states that seem to most successfully communicate with beneficiaries have carefully planned notice timing and developed content that better educates recipients about their rights and options.

In addition to print notices, websites can be a valuable tool for communicating with people who have or will soon have Medicare. From survey responses and supplemental research, Medicare Rights found that very few states link to Medicare information from state Medicaid websites, foregoing an opportunity to provide more information to Medicaid recipients who may be approaching Medicare eligibility. In addition, Medicare Rights found that state websites often do not have links to applications for traditional Medicaid programs or for MSPs. Where MSPs or Medicaid are referenced, websites often use state-specific terms instead of clearly marked generic identifiers that may be more understandable to a broad audience.

Promising practices

- Provide advance notice of approaching Medicare transition. Several states notify individuals turning 65 that they are about to lose their Adult Group Medicaid at least one month in advance. Connecticut, for example, sends out a notice two months in advance of an individual's 65th birthday. New York sends a notice even further in advance—three months before an individual turns 65. As CMS notes, "This type of early outreach allows states to redetermine eligibility for beneficiaries before they no longer meet the eligibility requirements of the Adult Group."[13] A few states have also had success giving advance notice to those who are becoming Medicare-eligible due to disability.

- Provide clear notices. Medicare Rights found that higher quality notices tend to provide more information in a clearer way, and to provide more context about benefits and next steps. For example, this notice from Louisiana informs the beneficiary that she is losing her Adult Group Medicaid because she is "entitled to or enrolled in Medicare" and that she is newly eligible for the SLMB program. It also gives the timeline for when benefits will begin:

The following decision has been made on your existing coverage:

_____'s Medicaid in the Adult Group Exp. Program will end on 03/31/2017 because you are entitled to or enrolled in Medicare benefits Policy reference MEM H-3500.

However, _____ has been found eligible for the Specified Low Income Beneficiaries (SLMB) program. Beginning 04/01/2017 , the Medicaid Program pay only your Medicare Part B premiums Policy Reference MEM H-1100; H-1300; H-2000

The automated process used to pay your Medicare premiums may take up to 90 days after you are certified. You will be reimbursed by Social Security for any premiums you have paid, back to the effective month of coverage In March 2018 , we will review your eligibility. If additional information is needed at that time, we will contact you.

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[13] Centers for Medicare & Medicaid Services, "CMCS Informational Bulletin: Strategies to Streamline Transitions for Medicaid eligible Beneficiaries Who Newly Qualify for Medicare" (June 7, 2017), *available at* https://www.medicaid.gov/federal-policy-guidance/downloads/cib060717.pdf.

- Request advocate and consumer input on notices and incorporate feedback. In several states, including California, Louisiana, and New York, the Medicaid agency officially or on an ad hoc basis accepts stakeholder feedback to improve notice language. Advocates in these states point to significant improvements in the effectiveness of the notices as a result.

- Include information in notices about MSPs and next steps. Connecticut includes an ABD Medicaid application and an MSP application with its notice regarding an individual's upcoming ineligibility for Adult Group Medicaid. As previously discussed, Louisiana assesses individuals before the original notice is mailed and is usually able to notify individuals of their termination from Adult Group Medicaid and their eligibility for Medicare and an MSP at the same time. This streamlined timeline is extremely beneficial for both the individual, who has clear information, and the state, which does not have to process extraneous applications.

- <u>Provide online information including specifics about Medicare enrollment rules.</u> Several states include comprehensive Medicare information either included on or linked through their Medicaid agency websites. For example, Indiana's Medicaid site has a link titled "Medicare Assistance"[14]:
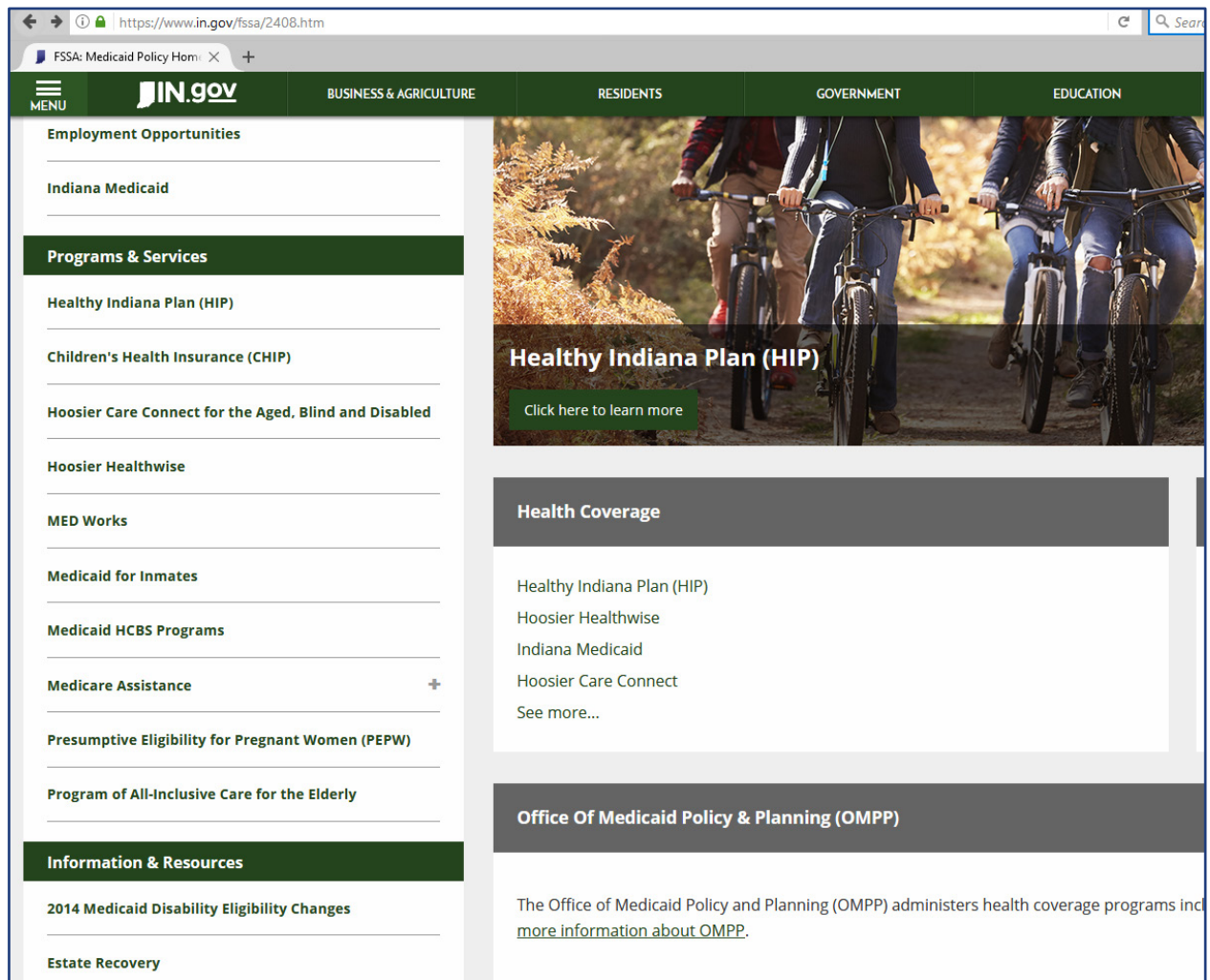
[14] "Medicaid Policy Home," Indiana Family and Social Services Administration (last visited August 24, 2017), *available at* https://www.in.gov/fssa/2408.htm; "Medicare Coverage," Indiana Department of Insurance (last visited August 1, 2017), *available at* http://www.in.gov/idoi/2497.htm.

- This link connects the reader to a strong state site with Medicare information prominently displayed about enrollment periods, penalties, and how to enroll. Indiana's Medicare information page also includes a link to an MSP page through the intuitive title "Help Paying for Your Medicare Costs"[15]:
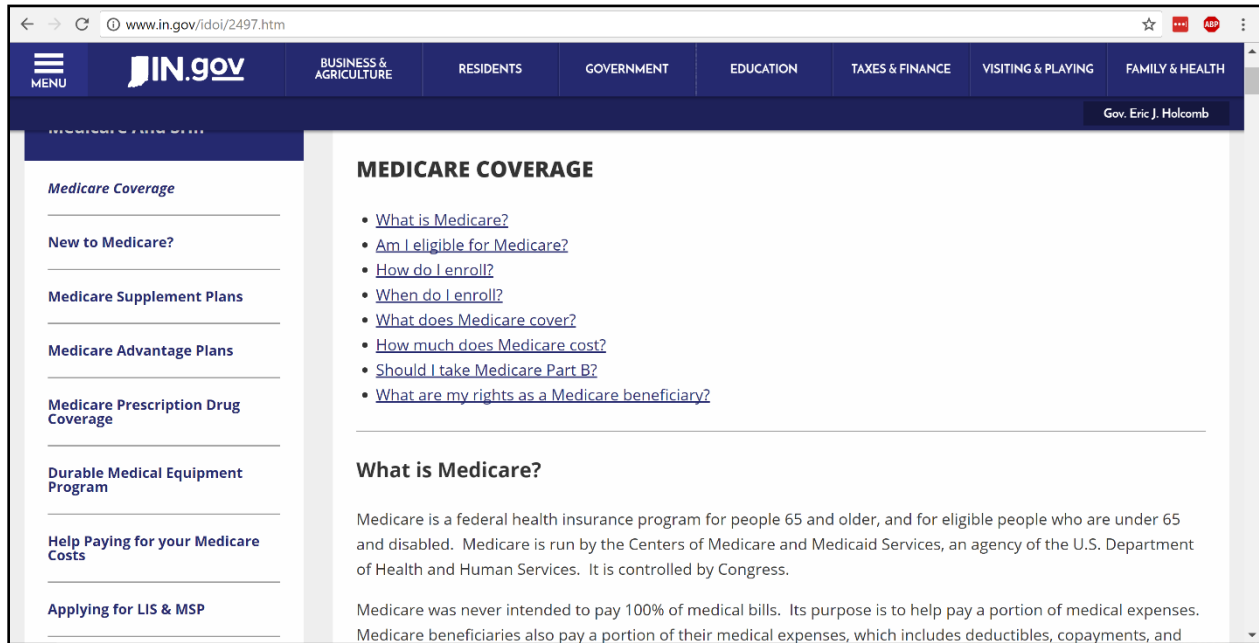
- Indiana's MSP page deserves special recognition for explicitly identifying Medicaid as the program supplying MSP assistance: "Indiana helps eligible, low-income beneficiaries pay for Medicare with the Medicaid program. Medicaid is a health care program that helps pay for medical services for people who meet specific requirements." This linkage helps to avoid confusion that can arise when people seek help with Medicare costs but do not understand that they are correctly being redirected to Medicaid.

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[15] "Help Paying for your Medicare Costs" Indiana Department of Insurance (last visited August 1, 2017), *available at* http://www.in.gov/idoi/2513.htm.

- Alaska also has substantial Medicare information available on its Health and Social Services website,[16] including not only basic Medicare information, such as who is eligible and how to apply, but also what happens if a Medicare-eligible person has other coverage and how Medicare works with various insurance options:

Simply having this information available may notify even a casual reader that there is more to Medicare coverage than might meet the eye, particularly when navigating the transition to Medicare and Medicare's coordination with other types of insurance.

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[16] "Getting Ready for Medicare?" Alaska Department of Health and Social Services, Senior and Disabilities Services (last visited August 1, 2017), *available at* http://dhss.alaska.gov/dsds/Pages/medicare/medicare.aspx.

- Provide jargon-free online information that can be easily navigated. Washington's Medicare page is one of the most comprehensive that Medicare Rights reviewed, with intuitive navigation and page titles that avoid jargon.[17] Oregon's SHIP also has a streamlined and intuitive Medicare-oriented website, and is one of the rare sites, along with Alaska and California, that includes information on which insurer pays first and which pays second—an important point for people to understand as they consider Medicare enrollment[18]:
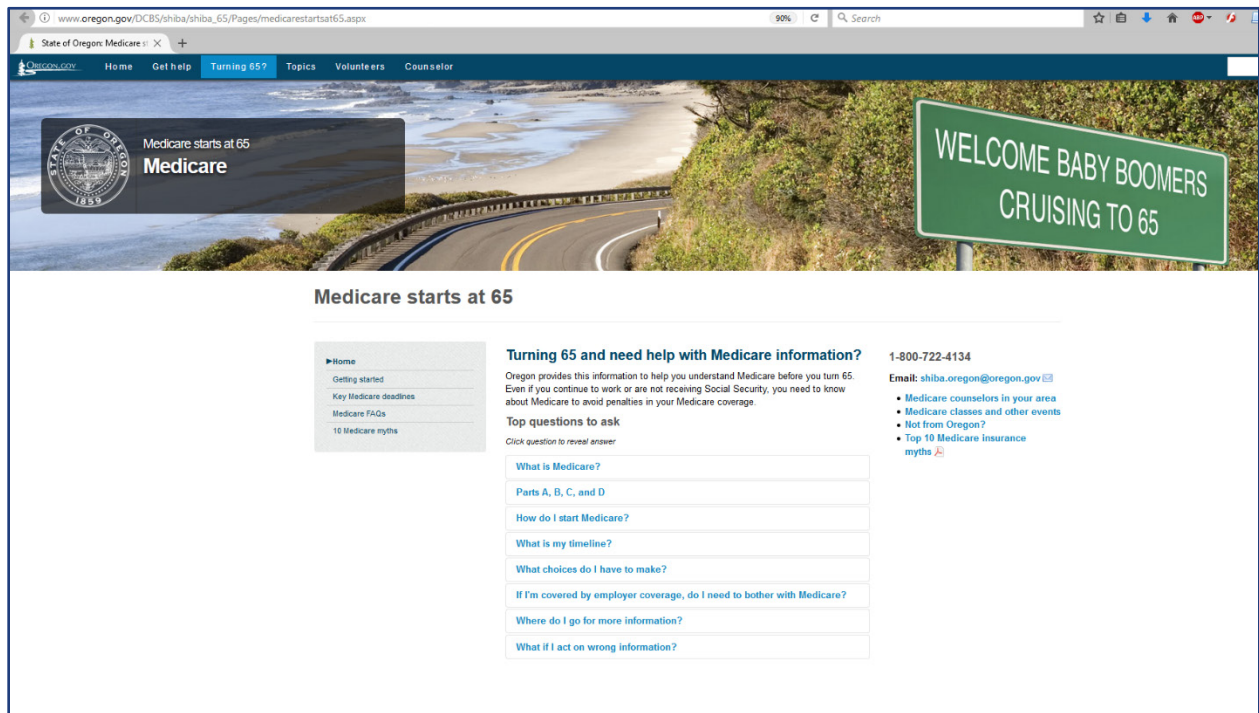
Challenges

- Lack of timeliness. In many states, despite having processes in place to provide timely notices, there can be execution problems that prevent beneficiaries from receiving notices on time. Problems can include databases lacking current addresses and other database errors, backlogs, systems conflicts, and human error.

- Reaching beneficiaries. One theme that Medicare Rights saw in many states was that beneficiaries do not always read even the best notices. This is especially problematic as individuals near 65 and become inundated with mailings and marketing materials about Medicare. One good way of addressing this problem is involving multiple stakeholders in the notice design process, so that states can learn what is the most memorable,

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[17] "Medicare" Washington State Office of the Insurance Commissioner (last visited August 1, 2017), *available at* https://www.insurance.wa.gov/medicare.

[18] "Turning 65 and need help with Medicare information?" State of Oregon (last visited August 1, 2017), *available at* https://www.oregon.gov/DCBS/shiba/shiba_65/Pages/medicarestartsat65.aspx.

noticeable, or eye-catching way to package notices. With regards to online information, even states with high-quality websites with strong content may not be organizing the information as usefully as possible or putting the information in front of the right people. Finding ways to capture the attention of internet users is a challenge for even the highest-spending corporations, so it is unsurprising if many states do not excel.

- <u>Language access.</u> Ensuring that beneficiaries receive notices in a language they can understand is a requirement, but can be difficult to guarantee, especially for less common languages in a state.

III. ABD Medicaid and MSP eligibility determinations and redeterminations

As individuals transition from Adult Group Medicaid to Medicare, understanding and completing applications can prove confusing and difficult to navigate for both consumers and those serving them. In cases where systems are not automated, applicants may struggle to find Medicare, ABD Medicaid, and/or MSP applications, to understand which applications are relevant, to fill them out properly, to submit them on time, and to follow up with any necessary steps. But many states are taking actions to automate, simplify, streamline, and better explain these processes.

As mentioned in the section on identifying eligible beneficiaries, states must first decide which applicants are eligible for ABD Medicaid and MSP programs using either applications with self-attested information, data matching, or a combination. Thereafter, states need an ongoing process to determine if a current beneficiary continues to be eligible for these programs. Based on survey findings, there are a variety of approaches to these issues.

As previously noted, there is no asset test for Adult Group Medicaid, and the income limits are generally higher than for either ABD Medicaid or MSPs. This means that many people who were eligible for Medicaid in the Adult Group may be ineligible for ABD Medicaid or MSPs because their assets or income are too high. Fortunately, the asset limit can be eliminated if states choose. States also have the flexibility to raise income limits for ABD Medicaid and for MSPs.

Promising practices

- <u>Eliminate asset limits and increase income eligibility for MSPs.</u> Several states, like Arizona, Oregon, and New York, have eliminated the asset limit for MSPs. Other states, like Indiana, have increased MSP income eligibility. A third group, including Connecticut and the District of Columbia, have done both.[19] These actions reduce administrative and beneficiary burden and could help states avoid increases in uninsured residents, especially in rural and low-income areas.[20] According to CMS, in 2017: [M]ultiple states have used the authority under section 1902(r)(2) of the Social Security Act (the Act), which permits states to apply less restrictive income and asset methodologies than those of the Supplemental Security Income (SSI) program, in determining eligibility for MSP or other eligibility groups. By exercising this authority, states can facilitate alignment of the eligibility rules between MSP and Medicaid expansion group, which can ease the transition of beneficiaries from the expansion group to MSP when they become Medicare eligible. A number of states also have used section 1902(r)(2) of the Act to provide MSP to a greater portion of Medicare-eligible individuals losing coverage under the Medicaid expansion group by disregarding certain amounts or types of income and assets of a beneficiary, his or her spouse or other family members in determining eligibility for coverage under MSP or other non-MAGI [ABD] eligibility groups.[21]

- <u>Provide automatic assessment and redetermination for eligibility via data match.</u> Ideally, such assessments would happen before the applicant or beneficiary is ever contacted for information in either an application or redetermination process. Louisiana, for example, makes every effort to use data already available to automatically assess individuals for ABD Medicaid and MSP programs as they transition from Adult Group Medicaid to Medicare. This kind of proactive approach prevents the majority of individuals from having to apply or reapply for benefits, limiting the risk that they will go without needed support. In many states, a beneficiary with Medicaid has already submitted sufficient information to be considered for an MSP. In California, for example, counties are expected to automatically consider Medicaid applicants for MSPs when they become Medicare-eligible, without these individuals needing to submit an MSP application.

- <u>Offer a thoughtful no-wrong-door application process.</u> Several states have adopted no-wrong-door systems, typically meaning that a single, general application covers several programs. The District of Columbia's combined application, for example, covers

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[19] National Council on Aging, "Medicare Savings Programs (MSPs): Eligibility and Coverage (2017)" (March 2017), *available at* https://www.ncoa.org/wp-content/uploads/medicare-savings-programs-coverage-and-eligibility.pdf.

[20] For more on how states may benefit from expanding eligibility for Medicaid programs, including MSPs, see Cindy Mann & Melanie Bella, "CMCS Informational Bulletin: Enrollment and Retention Flexibilities to Better Serve Medicare-Eligible Medicaid Enrollees" (January 23, 2015), *available at* https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-23-2015.pdf.

[21] Centers for Medicare & Medicaid Services, "CMCS Informational Bulletin: Strategies to Streamline Transitions for Medicaid-eligible Beneficiaries Who Newly Qualify for Medicare" (June 7, 2017), *available at* https://www.medicaid.gov/federal-policy-guidance/downloads/cib060717.pdf.

SNAP/food stamps, cash assistance, interim disability assistance, Medicaid, MSPs, and other health programs. It is important, however, that such combined applications do not result in too much burden for those who are applying only for one program and that programs *not* included in the application are still promoted effectively.

- Provide targeted applications. This recommendation complements the no-wrong door approach in the District of Columbia, where individuals can be screened for an MSP via either the multi-program general application or another, shorter, QMB-only application that requires no extraneous information. This combination of both inclusive and targeted applications aids access.

- Provide online forms and applications in addition to paper forms and applications for those who need them. Online availability of applications can help increase accessibility, reduce waste, decrease mailing time and expense, minimize administrative burden, and allow remote third parties to help applicants complete applications. Online availability of applications appears common. That said, while online access is important, maintaining paper applications for those who need or want them is also necessary. Some applicants do not have internet access or do not trust the security of information supplied on the internet.

- Provide a soft transition landing. Surveys indicated that sometimes individuals may transition out of Adult Group Medicaid before having the opportunity to be assessed for other programs. This is especially likely to happen when it is difficult for the state to identify individuals—such as those receiving SSDI—and inform them that they are approaching Medicare eligibility and will lose their Adult Group Medicaid. To help individuals avoid gaps in coverage and other complications from not being enrolled in another program, California places individuals who are no longer eligible for Adult Group Medicaid—but have not yet been assessed for other forms of Medicaid—into a temporary "soft pause." This process keeps individuals in Adult Group Medicaid long enough to allow county social services departments to evaluate their eligibility for other Medicaid programs. Only once that evaluation is complete are individuals removed from Adult Group Medicaid. This softer transition ensures that Medicare beneficiaries are not cut off from assistance before the state's determination processes are complete.

- Align redetermination schedules among multiple benefits. Redeterminations for Medicaid, MSPs, and other programs can be confusing and burdensome for beneficiaries. Medicare Rights finds that individuals sometimes inadvertently throw away redetermination notices or are confused about the dates that different benefits expire and the actions they need to take to keep them. Even if states are not prepared to automate redetermination processes—so that, for instance, individuals do not need to do anything to keep their benefit so long as their income and assets have not changed— states can simplify the redetermination process by aligning schedules across various programs. In Connecticut, for example, beneficiaries can request the same

redetermination date for Medicaid and their MSP as well as for their SNAP/food stamp benefit.

Challenges

- <u>Incorrect rejection of applications.</u> Some states require that multi-program applications be filled out entirely, even when missing data are not relevant for determining eligibility for every program. For example, if a state uses one application for both ABD and MSPs but has an asset limit for ABD and no limit for MSPs, the MSP application process should continue even if the applicant did not include asset information.

- <u>Fiscal uncertainty and increasingly constrained state budgets.</u> Although state health systems might benefit in the long run by increasing eligibility for ABD Medicaid and MSPs—for instance through lessened administrative burden and fewer uninsured residents[22]—such actions require an up-front investment. Tight budgets and uncertainty regarding the future of Medicaid and related programs may make it more difficult for states to justify putting more people on their Medicaid rolls, even if such a policy change creates long-term stability.

- <u>Short redetermination periods.</u> States have some flexibility in deciding how often to conduct eligibility redeterminations for state programs. In some states, an individual only has a benefit for six months before being required to recertify, instead of the year-long benefit that exists in other states. Short redetermination periods can cause "beneficiary churn" if people inadvertently drop out of the program because they miss recurrent deadlines or misunderstand their renewal obligations. State administrations can also feel the burden of beneficiary churn, as it requires more staff to manage more frequent determination and redetermination processes.

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[22] *Id.*

Conclusion

That so many states are finding promising ways to aid beneficiaries in transitioning seamlessly to Medicare from Adult Group Medicaid is cause for optimism. Such promising practices demonstrate that there is a path forward for states to ease these transitions, benefitting beneficiaries as well as state agency staff.

Nevertheless, it is clear that there is much to do to improve transitions to Medicare, ABD Medicaid, and MSPs from Adult Group Medicaid. The Medicare Rights Center, in its surveys and interviews with a variety of states, found that improvements can be made to identification of transitioning individuals, communications to this population, and determination and redetermination protocols. It is important, however, to keep these transitions in the proper context. Medicaid's Adult Group is in its infancy; early adopter states began this coverage in 2014, and seven states have joined since then. Adult Group Medicaid's income and asset limits do not align with ABD Medicaid or MSPs, and the inability of an individual to be dually enrolled in Medicare and Adult Group Medicaid creates new issues for states to address.

Various political issues that have led to doubt about the long-term prospects for Adult Group Medicaid may also have affected how states have prioritized issues with this population. It is also clear that some systemic issues, like staffing, do not have an easy solution. Ever-tightening state budgets will affect how states can hire and retain an adequate staff. Fortunately, other paths may not require so many resources. For example, inviting input into notices and websites, providing streamlined applications, and aligning redetermination periods can be relatively straightforward without long-term monetary commitments from states. In addition, states can continue to identify weak spots in technology and consider short-term and longer-term fixes. Significant progress has already been made in several states after rough transitions into new computer systems.

All told, whenever individuals must transition from one system to another, challenges inevitably arise. It is the hope of Medicare Rights, NCOA, and others that states can learn from one another and take small steps—such as those outlined on this paper—toward improving transitions from Adult Group Medicaid to Medicare. The population depending on Medicare and Medicaid continues to grow, and improvements made now will benefit individuals and their families for decades to come.

Appendix

Questionnaire

https://www.surveymonkey.com/r/5FQ2W2B

1. Name

2. State

3. Agency or Organization

4. Title

5. Can I contact you with any follow-up questions? Y/N Contact information _____

6. Is there anyone else you can think of who would have information about these programs or processes who might be willing to speak with me? Y/N Contact information _____

7. Could I have a copy of any state notices or state policy transmittals on these topics? Y/N Instructions _____

8. How and when does your state identify individuals who have lost or are about to lose eligibility for the adult group in Medicaid? For example, processes, systems, agencies, etc.

9. How and when does your state screen individuals who have lost or are about to lose eligibility for the adult group in Medicaid for other categories of Medicaid? For example, processes, systems, agencies, etc.

10. Under what circumstances and when does your state reach out to the individual who may be eligible, and what is requested of them? For example, provide additional information, income and asset records, fill out a new application, etc.

11. As individuals lose eligibility for the adult group, what official notices do they receive, and when?

12. Does anything else accompany the notices? For example, applications, information on MSPs or non-Medicaid programs, etc.

13. Does your state do any active outreach to or notify people with Medicaid about their Medicare eligibility? If so, when?

14. Do you know what barriers your state faces with any of these issues? For example, identification of those eligible for Medicare and/or traditional Medicaid, screening, notification, etc.

15. What outside support, if any, would make any of these processes easier for the state? For example, policy changes, financial resources, private partnerships, etc.

16. Please provide any additional comments about any topic in this questionnaire.