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Streamlining Enrollment & Eligibility into Medicare Savings Programs and Notification

Division of Welfare and Supportive services

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Department of Health and Human Services

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Agenda

- Review of the Medicare Savings Program eligibility criteria and benefits
- Review the Center for Medicaid and Medicare Services (CMS) Six Final Rules to Streamline Enrollment & Eligibility into Medicare Savings Programs (MSP)
- Review Nevada's Division of Welfare and Supportive Services (DWSS) proposed solutions to CMS final rule.

MSP Eligibility and Benefits

- The Medicare Beneficiary program provides qualified Medicare eligible individuals with coverage of their Medicare premiums, as well as co-pays and deductibles for some qualified beneficiaries. Individuals enrolled in the Medicare Beneficiary program are also entitled to have reduced Part D prescription drug premiums through Social Security's Low-Income Subsidy (LIS) program.
- Individuals eligible for Social Security's LIS program receive reduced premium payments for their Part D prescription drug program. The Social Security Administration transmits applicant information from LIS applicants to DWSS. DWSS must treat this data as an application for the Medicare Beneficiary programs

Medicare Savings Programs

QMB: Qualified Medicare Beneficiaries

- Income at or below 100% of the Federal Poverty Level (FPL). Changes yearly. Changes are effective April 1st every year.
  - 2023 FPL:
    - Individual $0.00-1215.00
    - Couple: $0.00-$1643.00
- Resources no greater than $9,430 for an individual, or $14,130 for a married couple. Changes yearly. Effective 1/1/2024
- Nevada pays Medicare premium (buy-in).
- Client receives Medicaid card used in conjunction with Medicare to cover co-pays and deductibles on Medicare-covered expenses.
- No prescription coverage.
- Coverage begins the month following the month the eligibility decision is made.
- No prior medical coverage available.

SLMB: Special Low-Income Medicare Beneficiaries

- Income between 101% and 120% of FPL. Changes yearly. Changes are effective April 1st every year.
  - 2023 FPL:
    - Individual: $1215.01-1458.00
    - Couple: $1643.01-$1972.00
- Resources no greater than $9,430 for an individual, or $14,130 for a married couple. Changes yearly. Effective 1/1/2024.
- Nevada pays Medicare premium only. No Medicaid card.
- Coverage begins the month of application.
- Prior Medical coverage is available (3 months prior to date of application).

Medicare Savings Programs, cont.

QI: Qualified Individuals

- Income between 121% and 135% of the FPL. Changes yearly. Changes are effective April 1st every year.
    - 2023 FPL:
        - Individual: $1458.01-1640.00
        - Couple: 1972.01-2219.00
- Resources no greater than $9,430 for an individual, or $14,130 for a married couple. Changes yearly. Effective 1/1/2024
- Nevada pays client's Medicare premium only.
- Begins the month of application.
- Prior Medical coverage is available (3 months prior to date of application).

QDWI: Qualified Disabled Working Individuals

- Covers only Part A premiums for disabled individuals who lose free Part A due to earnings exceeding the Substantial Gainful Activity (SGA) limits established by the Social Security Administration (SSA).
- Under age 65.
- Continue to meet SSAs disability criteria.
- Not otherwise entitled to Medicare hospital coverage.
- Have net countable income below 200% of FPL. Changes yearly. Changes are effective April 1st every year.
    - 2023 FPL:
        - Individual: $1640.01-$2430.00
        - Couple: $2219.01-$3287.00
- Resources no greater than $4,000 for an individual, and $6,000 for a married couple.
- Not eligible for any other Medicaid assistance category.

Medicare and Buy-In

1. **Who is eligible for Medicare?**
    1. US citizens or Lawful Permanent Residents (LPRs) age 65 or older;
    2. Persons under age 65 who have been receiving Social Security disability benefits for 24 months;
    3. Persons with end-stage renal disease.
2. **Persons eligible for Medicare must enroll when eligible, as the State will pick up the premium at no cost to the individual.**
3. **Nevada pays Medicare premiums for eligible individuals through the buy-in program.**
    1. If already enrolled in Part A, but not Part B, DWSS can initiate Part B by accretion.
    2. If already enrolled in Part B, but not Part A, DWSS can initiate Part A by accretion.
    3. Conditional Part A is available to individuals who appear to be QMB eligible. These individuals are required to complete a special form - the Conditional Part A Enrollment form and take it to SSA in order to enroll. They have 20 days to provide proof of enrollment to DWSS, at which time DWSS will notify DHCFP requesting the accretion.
        1. **DWSS does not post eligibility until the Conditional Part A form is returned, so if the client never returns the form, they will not be billed for the premium.**

General Eligibility Information and Eligibility Process

- All applicants/recipients must meet federal and state eligibility requirements:
  - Residency
    - Must be living in Nevada with the intention of making Nevada their permanent home.
  - Citizenship
    - Must be a US citizen or have legal immigration status (Lawful Permanent Resident-LPR residing in the US for 5 years).
  - Social Security Number
    - Must be able to furnish a valid SSN.
  - Financial
    - Must be within all income and resource limits for the program.

General Eligibility Information and Eligibility Process, cont.

- **What happens when an application is received, or conversion requested?**
  - Registered in the DWSS eligibility system.
  - Reviewed by a case worker.
  - Client pended for any documents or information needed for processing.
  - Case decision made.
- **How long does it take to approve or deny?**
  - 45 days for aged or blind; 90 days for disability determination by Social Security Administration (SSA) or Division of Health Care Finance and Policy (DHCFP)

Rule #1: Enrollment of Low-Income Subsidy (LIS) Applicants into Medicare Savings Programs (MSP)

- Center for Medicaid & Medicare Services (CMS) require that states provide individuals applying for Low-Income Subsidy (LIS) through SSA are effectively applying for the Medicare Savings Programs (MSPs).
- States are required to notify LIS applicants of the requirements to be evaluated for full Medicaid. This notification must be separate from any requests for additional information necessary for the determination of MSP eligibility, the following:

(1) Information about the availability of Medicaid benefits and requirements that include the scope of such benefits and responsibilities of the individual applying for such benefits; and

(2) An opportunity to furnish such additional information as may be needed to determine whether the individual is eligible for such additional Medicaid benefits.

(3) States would still need to describe rights and responsibilities and applicable estate recovery rules, obtain a signature for enrollment, and seek additional information necessary for full Medicaid determinations.

Compliance date 4/1/2026

Resolution for LIS Applicants into MSP

Proposed Resolution:

- Nevada has accepted LIS application and has treated LIS applications as an application for eligibility under the Medicare Savings Programs (MSP) since 2010.
- A Second Notice must be mailed to LIS applicants informing them of the information needed for full Medicaid evaluations, including Rights and Obligations (R&O) and Medicaid Estate Recovery (MER).
- This may require a trigger to be added to AMPS that will instruct the system to generate and mail out a second notice with this information that is separate from any 2429 or Notice of Decision.

Rule #2: LIS Applicant Income Attestation

- CMS, § 435.952(e)(1)(i) and (ii), prohibit States from requesting documentation for dividend and interest income prior to making a determination of MSP eligibility with the following exception:
  - When the agency has information that is not reasonably compatible with the applicant's attestation on the LIS application.

Compliance date 4/1/2026.

Resolution to LIS Applicant Income Attestation

Proposed Resolution:

- Update the Unearned Income BAP regarding specific income sources that are to be excluded from budget evaluations for LIS applications.
- States MAY under the authority of section 1902(r)(2)(A) of the Act, utilize methodologies less restrictive than the SSI program in determining MSP eligibility, which includes the authority to disregard otherwise-countable income and/or resources, such as the income and/or resources of a spouse.
- It is unknown if this is restricted to just LIS applications or if its available for all Medicaid applicants. CMS guidance will be pursued to ensure compliance.

Rule #3: LIS Applicants Attestation to Resources

- CMS section 1902(a)(19) and § 435.952(e)(2)(i) require States accept applicants' attestation of the value of any non-liquid resources (e.g., burial funds, life insurance)
- Section 1613(d)(1) applies to both LIS and MSP determinations that burial funds are to be excluded, up to $1,500, for the applicant (and an additional $1,500 for their spouse) so long as the burial fund is "separately identifiable and has been set aside."
- Under proposed § 435.952(e)(4)(i)(A), if an individual attests to having a life insurance policy with a face value in excess of $1,500, consistent with current regulations at § 435.948, States may accept the attested cash surrender value , life insurance policies
- § 435.952(e)(2)(ii) clarifies that States must request documentation prior to making an initial determination of eligibility if they have information that is not reasonably compatible with the applicant's attestation in accordance with § 435.952(c)(2).

Compliance date 4/1/2026.

Resolution to LIS Applicants Attestation to Resources

Proposed Resolution:

- Update the resource BAP and eligibility budget to automatically exclude the first $1500 of a qualified resource. This feature is similar to other automatic disregards of income used in budgeting but will now apply to certain resources.
- States MAY under the authority of section 1902(r)(2)(A) of the Act, utilize methodologies less restrictive than the SSI program in determining MSP eligibility, which includes the authority to disregard otherwise-countable income and/or resources, such as the income and/or resources of a spouse.

Rule #4: State Option to Allow 90-Day Post Eligibility Verification

- CMS will allow a post-eligibility verification request as a State Option.
- States that choose to conduct post-eligibility verification are required to allow individuals at least 90 calendar days to respond to requests for additional information.
- Post-eligibility will not result in a citation or error upon review due to non-compliance from the customer after approval of post verification request.
- Premiums and services covered will not result in a fiscal citing.

Compliance date 4/1/2026-*State option.

Resolution to State Option to Allow 90-Day Post Eligibility Verification

Proposed Resolution:

- Ensure the system allows for 90-day pending of LIS applications after initial approval and the automated actions required if the 90-days expire and the household fails to cooperate.

Rule #5: Family Size Re-Defined

- Family size is defined in § 423.772 to include the applicant, the applicant's spouse (if the spouse is living in the same household with the applicant), and all other individuals living in the same household who are related to the applicant and dependent on the applicant or applicant's spouse for one-half of their financial support.
- CMS confirm that to comply with this rule to use the "family size" definition in § 423.772 for MSP eligibility determinations, States would need to treat "related to" the applicant individuals who are related by blood, marriage, or adoption.
- CMS to amend § 435.601 ("Application of financial eligibility methodologies") to create a new paragraph (e), in which CMS to define "family size" for purposes of MSP eligibility.

Compliance date 4/1/2026.

Resolution to Family Size Re-Defined

Proposed Resolution:

- LIS applications will allow for family size to be used in making eligibility decisions. This may involve a change to the eligibility engine to allow for household size to factor into the income and resource limits used in making the eligibility decision on LIS/MAABD applications.

Rule #6: Automatic Enrollment of SSI Recipients into MSP

- CMS to require States to deem individuals enrolled in the mandatory SSI or 209(b) group who have premium-free Medicare Part A as eligible for the QMB group under new § 435.909(b)(1).
- QMB coverage would start the month following the month the State deems an individual eligible for the QMB group and starts paying the individual's Part B premiums under the buy-in agreement.

Compliance date 10/1/2024.

Resolution to Automatic Enrollment of SSI Recipients into MSP

Proposed Resolution:

- A new alert/edit will be required for SSI eligible individuals who become eligible for Medicare or turn age 65. This alert must create a task to inform staff of the need to take action to update eligibility to include the buy-in of Medicare for these SSI individuals.

Questions?