Bridging the Gaps Between Medicare and Medicaid: The Case of QMBs and SLMBs

by:

Margo L. Rosenbach, Ph.D.
Mathematica Policy Research, Inc.

and

JoAnn Lamphere, Dr.P.H
AARP

The Public Policy Institute, formed in 1985, is part of the Research Group of the AARP. One of the missions of the Institute is to foster research and analysis of public policy issues of interest to older Americans. This paper represents part of that effort.

The views expressed herein are for information, debate, and discussion and do not necessarily represent formal policies of the Association.

© 1998, American Association of Retired Persons. Reprinting with permission only.
AARP, 601 E Street, N.W., Washington, DC 20049
Acknowledgments

Many people contributed to this report. First and foremost, we recognize the efforts of Craig Caplan of the AARP Public Policy Institute in assembling the appendix table on state Medicaid program characteristics. We greatly appreciate all his research support and careful attention to detail. Several colleagues at Mathematica Policy Research also assisted in preparing this report. We thank Jim Verdier for his insights concerning the implications of our findings; Sajeed Kabir and Cheryl Young for research assistance; and Besaida Rosado for production assistance. AARP staff who made important contributions to this research effort include Mary Jo Gibson of the Public Policy Institute and John Luehrs in State Legislation. We gratefully acknowledge the efforts of Paul Saucier, at the University of Southern Maine, for reviewing the paper and providing important comments on the themes and recommendations. Finally, thanks are offered to the state Medicaid eligibility staff and Information, Counseling, and Assistance (ICA) program officials who so generously shared their time and perspectives with us.
Contents

Page

Executive Summary .................................................................i

Introduction ...............................................................................1

Origin of the QMB and SLMB Programs .............................................2

The Promise and Limits of Buy-In Protection ........................................4

Variations in QMB and SLMB Enrollment .........................................5

Study Objectives ..........................................................................6

Approach ...................................................................................6

Selection of States .......................................................................6

Data Collection ...........................................................................8

State Perspectives on the QMB/SLMB Programs ..............................8

Theme #1: The QMB/SLMB Programs Are Viewed as an Important Element of the Government's Patchwork Efforts to Protect Low-income Medicare Beneficiaries .................9

Theme #2: Grassroots Outreach Appears to Be the Most Effective Approach to Educating and Informing People About the Programs .........................................................10

Theme #3: States With More Generous Medicaid Eligibility Standards for Older Persons and Persons With Disabilities Have Higher QMB/SLMB Enrollment Rates ........................12

Theme #4: The Lack of Integrated Financial Protections for Low-income Medicare Beneficiaries Often Results in Fragmentation of Health Care Benefits and Duplication of Coverage .........................................................14

Theme #5: Structural Gaps in Eligibility and Benefits Limit the Financial Protections Available to Low-income Medicare Beneficiaries .........................................................15

Theme #6: Gaps in the Government "Safety Net" Occur Both Among Programs and Over Time ........................................................................16
Theme #7: The Eligibility Determination Process is Overly Complex, Resulting in Confusion Among Medicaid Beneficiaries and Medicaid Eligibility Workers .......................... 17

Theme #8: Obsolete or Incompatible Data Systems Act as Barriers to Effective Outreach and Eligibility Screening and Impede Tracking and Monitoring ........................................ 18

Theme #9: Coordination with the Social Security Administration is Inconsistent Across States, Resulting in Foregone Opportunities for Outreach to and Referral of Potentially Eligible Beneficiaries ........................................................................................................... 21

Recommendations for Improving the QMB and SLMB Programs .......................... 23

Recommendation #1: Better Data Are Required to Administer the QMB/SLMB Programs ............................................................................................................................. 24

Recommendation #2: National Commitment Is Required to Improve the Administration and Financing of the QMB/SLMB Programs ........................................................................................................... 25

Recommendation #3: New Approaches Are Required to Enhance Outreach and Enrollment in the QMB/SLMB Programs ........................................................................................................... 26

Recommendation #4: More Research Is Needed to Understand the Impact of the QMB/SLMB Programs on Health Care Use and Costs Over the Long Term ........................................ 27

Conclusion ............................................................................................................................... 28

References ............................................................................................................................... 29

Appendix 1: Medicare Cost-Sharing Requirements, 1998
Appendix 2: Definition of Dual Eligibles
Appendix 3: Medicaid Eligibility Criteria: State Choices for Low-Income Elderly, 1998
Appendix 4: Quality of Data on QMB/SLMB Enrollment
Appendix 5: Abbreviations Used in This Report
Executive Summary

**Background.** Many Americans assume that older persons are well protected against high out-of-pocket health care costs because of Medicare and the widespread availability of supplemental health coverage. Persons 65 years and over living in or near poverty (up to 125 percent of the federal poverty level), however, have out-of-pocket health costs that consume nearly a quarter of their annual income. (This average does not include the costs associated with long-term care.) The Medicaid program can extend the continuum of essential health care services and significantly reduce the economic vulnerability associated with advanced age and low income. Medicare beneficiaries who are dually eligible for full Medicaid coverage receive comprehensive benefits, such as coverage for prescription drugs and long-term care services.

The Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs provide partial protection to low-income Medicare beneficiaries by paying Medicare’s premium and cost-sharing requirements. The QMB program serves individuals with incomes at or below 100 percent of the federal poverty level; the state Medicaid program pays their Medicare Part A and Part B premiums and Medicare deductibles and coinsurance. Some of these individuals, at a state’s option, may qualify for full Medicaid benefits as well. The SLMB program pays only the Part B premium for people with incomes between 100 and 120 percent of poverty. Available data indicate that national participation rates in the QMB and SLMB programs generally have been very low.

**Purpose.** This study assesses state variations in Medicaid QMB/SLMB enrollment of low-income Medicare beneficiaries and identifies best practices among states in the administration of the QMB and SLMB programs. Medicaid’s QMB and SLMB programs make Medicare affordable for many low-income older Americans and help people to secure the medical services they need. Despite enactment of the QMB program nearly a decade ago, state implementation remains uneven. As a result, the QMB and SLMB programs appear to be reaching a fraction of those who might be eligible. This project was designed to provide insights, from different state perspectives, into some of the barriers that should be overcome to achieve improved financial protection for low-income older Americans.

**Methodology.** Mathematica Policy Research, Inc. conducted telephone interviews with officials in 10 states to elicit qualitative information about how state Medicaid programs have implemented the QMB and SLMB programs for low-income Medicare beneficiaries. Information was sought about innovative ways to increase enrollment
among those who are eligible for QMB and SLMB coverage. The 10 states participating in this study were: California, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Mexico, New York, Tennessee, and Texas. States were selected based on their geographic distribution, population characteristics, variation in QMB and SLMB enrollment, and range of Medicaid program characteristics. Interviews were conducted during February and March 1998 with two officials in each state: a state Medicaid eligibility official and a representative of the Information, Counseling, and Assistance (ICA) program (often referred to as the Health Insurance Counseling and Assistance Program, or HICAP).

**Findings.** The QMB and SLMB programs fail to reach a sizable proportion of potentially eligible individuals in most states. Due to data limitations, however, it is impossible to determine, with any precision, state-by-state participation in the QMB and SLMB programs. States report that the Third Party Premium Billing File of the Health Care Financing Administration (HCFA) undercounts the number of QMBs and SLMBs, particularly those individuals who receive full Medicaid benefits in addition to Medicare premium and cost-sharing protections.

Our research indicates that the QMB and SLMB programs’ value is recognized by many state officials, despite their complexity and uneven implementation across states. State Medicaid and ICA officials have come to view these programs as an essential part of the patchwork of programs and services offered to low-income older persons. Efforts to achieve high QMB and SLMB enrollment in a state often are accompanied by more generous financial eligibility standards to enable greater numbers of older persons to qualify for full Medicaid coverage.

This study identifies specific strategies states have adopted, such as creative outreach efforts, that can be shared with other states to improve participation in the QMB and SLMB programs. Nevertheless, complex Medicaid eligibility and income verification processes, rigid federal and state administrative and data systems, and fragmentation of Medicare and Medicaid benefits impede efforts to achieve maximum participation in the QMB and SLMB programs.

**Conclusions.** For low-income Medicare beneficiaries, obtaining financial protection against their out-of-pocket health care costs is an important immediate objective. The Medicaid program provides critical assistance to low-income older Americans with their out-of-pocket health care costs. Federal leadership is recommended to develop national QMB and SLMB outreach strategies and to improve coordination across federal and state agencies in administering the QMB and SLMB programs.
BRIDGING THE GAPS BETWEEN MEDICARE AND MEDICAID: THE CASE OF QMBs AND SLMBs

Introduction

The Medicare program provides virtually universal health coverage to the nation’s older population (those 65 years and over) and one million persons with disabilities. Like most indemnity insurance plans, Medicare coverage requires the payment of premiums, deductibles, and coinsurance, which vary by type of service. (See Appendix 1 for Medicare’s premium and cost-sharing requirements, by type of service.) The majority of Medicare beneficiaries also have private supplemental health insurance to cover Medicare’s required cost-sharing and selected benefits not covered by Medicare, such as outpatient prescription drugs. Nearly nine out of 10 Medicare beneficiaries either have private supplemental insurance they have purchased individually (Medigap) or secured as a retirement benefit, or they have public coverage through the Medicaid program (Physician Payment Review Commission 1997).

Given the widespread availability of supplemental Medicare coverage through both private and public sources, one might believe that Medicare beneficiaries are well protected against out-of-pocket health care costs. The fact is, however, out-of-pocket health care costs remain a particular concern for older Americans (Gross et al. 1997).

- The average older Medicare beneficiary living in the community spends 19 percent of his or her income on health care costs.\(^1\) (This average does not include the costs associated with long-term care.)

- Among those living in poverty, out-of-pocket spending averages 35 percent of income, but ranges from 8 percent for persons with full-year Medicaid coverage to about 50 percent for those who do not receive Medicaid protection.

- Among those living on the margin of poverty (between 100 and 125 percent of poverty), health care costs consume 23 percent of income on average, but drop to only 4 percent among those with full-year Medicaid coverage.

These figures underscore the importance of Medicaid in protecting lower-income Medicare beneficiaries from the consequences of high out-of-pocket health costs.

There are numerous reasons that health care costs remain a significant burden for older Americans. Far more than any other age group, persons 65 and older need and seek medical services. For those who live on modest incomes, these medical services pose a special burden. Noncovered medical expenses (such as prescription drugs), the cost of

\(^1\) Throughout this report, the term “older Medicare beneficiary” refers to persons 65 years and over.
Medicare premiums and cost-sharing, the high cost of supplemental insurance, and the limits of Medicaid protection are factors that can result in profound economic vulnerability for many older persons, as well as people with disabilities who rely on Medicare coverage.

Persons who receive benefits from both Medicare and Medicaid are known as “dual eligibles” (see Appendix 2 for a definition of dual eligibles). For older persons who have full Medicaid coverage, Medicaid extends the continuum of essential health care protection and significantly reduces the economic vulnerability associated with advanced age and lower income. Older Americans can become eligible for Medicaid through several pathways. Those who are eligible for Supplemental Security Income (SSI) can enroll in Medicaid and receive full Medicaid benefits. In some states, SSI eligibility automatically results in Medicaid eligibility, whereas in other states—known as 209(b) states—those eligible for SSI must apply separately for Medicaid coverage. Thirty-five states offer “medically needy” coverage for those who qualify for Medicaid on the basis of high medical costs rather than on the basis of strict income or assets limits. Both categories often exclude many poor and near-poor Medicare beneficiaries (Moon et al. 1996).

Under federal law, states have the option of extending Medicaid coverage to certain additional persons. Eleven states have expanded Medicaid eligibility for elderly and disabled individuals with incomes at or below 100 percent of the federal poverty level (FPL). In addition, nearly all states have secured section 1915 waiver authority to provide home- and community-based services covered by Medicaid to those who otherwise would require institutionalization. Variations in state Medicaid eligibility categories for older persons are shown in Appendix 3.

Origin of the QMB and SLMB Programs

Additional population groups with Medicare coverage can receive partial Medicaid protection if they meet certain qualifications as defined in federal law. Although they are not usually entitled to the regular Medicaid benefit package, Medicaid will make certain health payments on their behalf. For selected Medicare beneficiaries, states are required to buy in to Medicare Part A and/or B:2

- The Qualified Medicare Beneficiary program serves individuals with modest resources (up to $4,000 per individual or $6,000 per couple) who have incomes not exceeding 100 percent of the federal poverty level ($691 monthly income for an individual in 1998); the state Medicaid program pays their Medicare Part B premiums and cost-sharing amounts.

---

2States also are required to buy in to Medicare Part A for two groups—those who have not worked enough quarters to qualify for Social Security (but who qualify for the QMB program), and Qualified Disabled Working Individuals (QDWIs). QDWIs are eligible for payment of the Medicare Part A premium, provided they were eligible for Social Security disability benefits prior to engaging in “substantial gainful activity,” they still have the same disabling condition, their income is below 200 percent FPL, and they meet the resource requirement. These groups, however, are not the focus of this report.
• The Specified Low-Income Medicare Beneficiary (SLMB) program pays only the Part B premium for those with incomes between 100 and 120 percent of poverty ($825 monthly income for an individual in 1998) who meet the QMB resource requirements.

The QMB program was enacted by Congress as part of the Medicaid program in the Medicare Catastrophic Coverage Act (MCCA) of 1988 to protect low-income Medicare beneficiaries from the severe burdens of Medicare’s cost-sharing requirements and premium liabilities.\(^3\) The program was implemented through each state’s Medicaid program, with shared funding by states and the federal government. Before 1989, states had the option to “buy-in” aged and disabled Medicaid enrollees into Medicare by paying their Part B (and, occasionally, Part A) premiums, so that Medicare would cover a large share of their health care costs. The MCCA required states to phase in buy-in coverage for Medicare beneficiaries with incomes below the poverty line and assets less than $4,000 (or $6,000 for a couple).\(^4\) The law also modified Medicaid’s treatment of income and assets of a couple when one member becomes institutionalized (protection against spousal impoverishment). These Medicaid provisions were intended to be financed through a combination of Medicaid savings attributable to Medicare expansions, plus some general revenue financing (Congressional Research Service 1989).\(^5\) As noted, the Medicare expansions were never implemented; thus, the anticipated state Medicaid savings did not occur.

Congress expanded the buy-in program in 1993, by requiring state Medicaid agencies to pay the Medicare Part B premium (but no other Medicare costs) for SLMBs with incomes between 100 and 110 percent FPL. In 1995, SLMB eligibility was expanded to 120 percent FPL.

Under the Balanced Budget Act of 1997, Congress created a five-year block grant providing funds for states to pay all or part of the Part B premium for two additional groups of qualifying individuals (QIs): (1) Medicaid pays the full premium for those with

---

\(^3\) Although the Act was repealed in 1989, the Medicaid provisions were retained.

\(^4\) QMB coverage was phased in by income level over a three-year period, up to 85 percent FPL in 1989, increasing to 90 percent FPL in 1990, and 100 percent FPL in 1991.

\(^5\) Congressional documents addressing the Medicaid provisions indicate that, in general, neither the states nor the U.S. Department of Health and Human Services (DHHS) were supportive of enactment. Many state Medicaid officials, especially in the Southern states, were “concerned that their costs could rise significantly” with Medicaid expansions (Congressional Research Service 1989). DHHS correspondence asserted, “the mandated Medicaid buy-in … impinges on an area best left to the States” (House Energy and Commerce Committee 1987). However, the House Energy and Commerce Committee noted, “As a result of the proposed expansion of Medicare benefits … States, under their Medicaid programs, would realize significant savings…. In the view of the Committee, this Medicaid ‘windfall’ should be redirected towards catastrophic protection for the elderly and disabled poor.” The Congressional Budget Office estimated the net costs of these Medicaid provisions over the FY 1989-1993 period at $1.9 billion (CRS 1989).
A complete description of the relationship between the Medicare and Medicaid programs is beyond the scope of this report. Definitional clarity is important, however, to help the reader understand the concepts discussed in this report. According to HCFA, beneficiaries who are eligible for the QMB and SLMB programs are defined as a subset of the dual eligible population, and are generally recognized as a subset of the Medicaid “buy-in” program for low-income Medicare beneficiaries. Medicaid may also “buy into” Medicare for other populations but they are not the focus of this report. The Medicaid program does not pay for Medicare premiums and cost-sharing for all dual eligibles (such as the medically needy in some states). While some individuals receiving QMB benefits may qualify for full Medicaid benefits (at a state’s option and depending on their level of personal assets), not all older or disabled persons who receive full Medicaid coverage qualify for QMB benefits.

The Promise and Limits of Buy-In Protection

Although the state QMB and SLMB buy-in programs do not result in Medicaid coverage per se (such as coverage for prescription drugs and long-term care), they do aid in the financial well-being of low-income Medicare beneficiaries. Numerous reports have indicated, however, that the buy-in protections are not reaching all or even a sizable fraction of those who are eligible and could benefit from coverage. Early reports referred to the program as a “secret benefit” and “a promise unfulfilled” (Families USA 1991; 1993). Another report suggested that 63 percent of those eligible for QMB benefits, but only 10 percent of those eligible for SLMB benefits, participate (Moon et al. 1996). These estimates have been revised upward: 1998 estimates suggest that participation rates are 78 percent for QMBs and 16 percent for SLMBs (Moon et al. 1998).

These participation rates suggest that large numbers of eligible Medicare beneficiaries are not receiving benefits to which they are entitled. A 1998 Families USA report estimated that between 3.3 and 3.9 million people eligible for QMB and SLMB buy-in protection were not receiving these benefits. As a result, as much as $2 billion is being withheld from Social Security checks each year to pay for Medicare premiums that otherwise could be subsidized by the state Medicaid buy-in program (Families USA 1998).

---

6 Medicaid pays $1.07 per month toward the Part B premium ($43.80 in 1998) for those who qualify as QI-2s; this grant was intended to offset the cost of shifting home health care to Part B under the Balanced Budget Act of 1997. The interviews for this report took place when states were grappling with implementation of the new block grant for coverage of QI-2s. Without exception, the QI-2 provision was universally unpopular because of the high administrative costs associated with the monthly benefit of $1.07 ($12.84 annually). Several states estimated that the program cost three to five times more than the benefit, including the cost of determining eligibility, processing the application, modifying the data system, and cutting the check. Without exception, states were concerned that "Congress understand what it had done" by implementing a program with such limited benefits relative to the administrative costs.
What accounts for these participation rates? Many reasons have been offered to explain why large numbers of eligible Medicare beneficiaries are not enrolled (Families USA 1993; GAO 1994; and Neumann et al. 1994):

- Lack of knowledge about the program.
- Lack of understanding about the benefits of the program.
- Stigma associated with applying for a Medicaid (“welfare”) benefit.

Even when Medicare beneficiaries are aware of the program and its benefits, they may encounter significant obstacles (Nemore 1997). These include:

- Barriers in the application process, such as the use of lengthy and complex application forms, requirements to file application in person, and language or literacy barriers.
- Lengthy delays in actually becoming enrolled once eligibility has been determined.

Nemore concluded: “Administration of the buy-in programs by different Medicaid systems of the 50 states and the District of Columbia result in barriers to enrollment due to variations in outreach, application process and eligibility criteria that make the benefit unevenly available throughout the country.”

**Variations in QMB and SLMB Enrollment**

We explored the level of variation in QMB and SLMB enrollment across states. We obtained state-by-state information on QMB and SLMB enrollment for two purposes: (1) to select a sample of states with high, medium, and low levels of enrollment for interviews designed to identify “best practices”; and (2) to identify potential data problems by sharing the data with state officials during the telephone interviews.

As of July 1997, 2.7 million Medicare beneficiaries were enrolled in Medicaid as QMBs or SLMBs, according to HCFA’s Third Party Premium Billing File. This represents an estimated 7.5 percent of total Medicare Part B beneficiaries and about half of low-income Medicare beneficiaries (up to 120 percent FPL). There was wide variation across states. Enrollment ranged from a high of 20 percent of all Medicare beneficiaries in Mississippi to less than 1 percent in New Hampshire, Nebraska, and Alaska. Adjusting for the level of poverty among older Medicare beneficiaries, we found that enrollment exceeded 100 percent of the estimated number of low-income Medicare beneficiaries in Mississippi and Massachusetts, and that it was less than 5 percent in Rhode Island and Alaska.7

---

7Participation rates can exceed 100 percent for several reasons: (1) lack of precision of the
Readers should be cautious in interpreting these data. The Third Party Premium Billing File may undercount the extent of QMB and SLMB participation in some states because Medicare beneficiaries who qualify for QMB coverage plus full Medicaid benefits usually are not included in the QMB counts but, rather, are included in the total buy-in category on the HCFA file. To date, there has been no systematic national effort to determine the extent of the undercount in each state. Moreover, there are no credible sources of data on the number who potentially are eligible for assistance.

We conclude that it is impossible to determine, with any precision, state-by-state participation in the QMB and SLMB programs. For additional details on the data sources, results, and data limitations, refer to Appendix 4.

Study Objectives

Recognizing that there are wide variations among states in the level of enrollment in the QMB/SLMB program, we sought to identify sources of these variations. Are there "best practices" that may explain some of the variations? What could we learn that would help states, advocates, and policymakers enhance the QMB/SLMB programs or, more generally, improve financial protection for low-income Medicare beneficiaries?

This report is divided into three additional sections. The next section describes our approach, including the criteria used to select states for this study. The following section presents a series of themes that emerged from interviews with state officials. The final section presents recommendations for improving the QMB/SLMB programs.

Approach

Mathematica Policy Research conducted telephone interviews with officials in 10 states to elicit qualitative information on the application and enrollment process for QMBs and SLMBs. The interviews were conducted during February and March 1998. This section describes the selection of states for this study and the data-collection approach.

Selection of States

The 10 states participating in this study were: California, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Mexico, New York, Tennessee, and Texas. These states were selected to meet the following criteria: (1) capture the variation among states in rates of denominators of 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 not counted when determining eligibility).
QMB/SLMB enrollment; (2) include a sizable portion of the nation’s Medicare population; (3) obtain a broad geographic representation; (4) capture a range of population demographics; and (5) include states with varying Medicaid program characteristics.

First, we were interested in obtaining a cross-section of states with high, medium, and low enrollment of QMBs and SLMBs. We derived two enrollment measures based on the Third Party Premium Billing File: an unadjusted rate, reflecting QMBs/SLMBs as a percent of all Medicare Part B beneficiaries; and an adjusted rate, reflecting QMBs/SLMBs as a percent of low-income Medicare beneficiaries (those below 120 percent FPL). (See Appendix 4 for further information on measurement of QMB/SLMB enrollment.) Three of the selected states have unadjusted enrollment rates above 10 percent of Medicare Part B beneficiaries (Mississippi, Massachusetts, and California), whereas three have rates below 5 percent (Michigan, Minnesota, and New Mexico). Adjusting for the number of low-income Medicare beneficiaries, we found that two of the states appear to have rates exceeding 100 percent (Massachusetts and Mississippi), while two other states have rates above 50 percent (California and Florida).

Next, we wanted to overrepresent states with large Medicare populations, as well as states with substantial low-income populations. Together, the 10 states account for 42 percent of Medicare beneficiaries in the United States (as of July 1, 1997), 47 percent of total Part B buy-ins, 49 percent of QMBs, and 31 percent of SLMBs. The poverty rate in the sampled states ranges from less than 10 percent in Minnesota (9.2 percent) to more than 20 percent in Mississippi (23.5 percent) and New Mexico (25.3 percent). The 10 states combined include 42 percent of the African-American population and 75 percent of the Hispanic population in the United States.

These 10 states are dispersed across all four regions and nine Census divisions: two in the Northeast (Massachusetts and New York); two in the Midwest (Michigan and Minnesota); three in the South (Florida, Tennessee, and Texas); and two in the West (California and New Mexico). Four states are highly urbanized, with more than 90 percent of the state population residing in metropolitan areas (California, Florida, Massachusetts, and New York), while in four states at least a third of the population resides in nonmetropolitan areas (Minnesota, Mississippi, New Mexico, and Tennessee).

These states also cover a range of Medicaid program characteristics that may affect enrollment of dual Medicare/Medicaid eligibles. As a 209(b) state, Minnesota utilizes its own criteria to determine Medicaid eligibility of SSI recipients. The remaining states use federal criteria. Two states--Mississippi and New Mexico--do not cover the medically needy, an optional Medicaid eligibility category. Two states--Massachusetts, and Mississippi--extend full Medicaid eligibility for older and disabled persons up to 100 percent FPL. Two states--Tennessee and New Mexico--used a shorter form for QMB/SLMB applications.8

---

8In addition, New York began using a one-page application for SLMBs and QI-1s, effective August 14, 1998.
Data Collection

Telephone interviews were conducted in February and March 1998 with at least two officials in each of the 10 states: the state Medicaid eligibility official or a designated representative, and the state contact for the federally funded Information, Counseling, and Assistance (ICA) program. Because of our focus on outreach, application, and enrollment processes, we chose to interview state eligibility and ICA officials. In some cases, the eligibility contact was not located in the Medicaid agency but, rather, in a "family assistance" agency, which also might have responsibility for determining eligibility for welfare, food stamps, and other public assistance programs. The ICA contact most often was located within the state's agency on aging.

Letters were sent to each state, explaining our research objectives and outlining the questions for discussion. The interview protocol included a general description of the program, an assessment of outreach mechanisms and application process, the role of ICAs and community networks, barriers to enrollment, and recommendations for improving the program. Interviews with the ICA contacts averaged about 45 minutes; interviews with the Medicaid eligibility officials averaged 75 minutes.

State Perspectives on the QMB/SLMB Programs

Interviews with officials in the 10 states revealed that there is wide variability among states in how the QMB/SLMB programs have been implemented. Based on the interviews with state eligibility and ICA officials, we identified a series of common themes that provide insights into how the program is working and how it could be improved. The nine themes are:

1. The QMB/SLMB programs are viewed as an important element of the government’s patchwork efforts to protect low-income Medicare beneficiaries.

2. Grassroots outreach appears to be the most effective approach to educating and informing people about the programs.

3. States with more generous Medicaid eligibility standards for older persons and persons with disabilities have higher QMB/SLMB enrollment rates.

4. The lack of integrated financial protections for low-income Medicare beneficiaries often results in fragmentation of health care benefits and duplication of coverage.

5. Structural gaps in eligibility and benefits limit the financial protections available to low-income Medicare beneficiaries.

6. Gaps in the government “safety net” occur both among programs and over time.

7. The eligibility determination process is overly complex, resulting in confusion among Medicaid beneficiaries and Medicaid eligibility workers.
8. Obsolete or incompatible data systems act as barriers to effective outreach and eligibility screening and impede tracking and monitoring.

9. Coordination with the Social Security Administration is inconsistent across states, resulting in foregone opportunities for outreach to and referral of potentially eligible beneficiaries.

Interspersed throughout this section are "best practice spotlights" that highlight the efforts in four selected states. These vignettes display the diversity of program initiatives undertaken by states to serve the QMB/SLMB population better.

**Theme #1: The QMB/SLMB Programs Are Viewed as an Important Element of the Government’s Patchwork Efforts to Protect Low-income Medicare Beneficiaries.**

Before we began this study, we had the perception that QMB/SLMB enrollment was low because the program was not considered valuable or important to states. We had expected to encounter resistance to these programs during the interviews with Medicaid eligibility staff. States were perceived to have little incentive to support these programs. We recognized that some state officials had viewed the QMB/SLMB programs as an unfunded mandate enacted by Congress as a residual provision of the Medicare Catastrophic Coverage Act of 1988.

As a result of the interviews, however, we obtained a very different picture. The QMB/SLMB programs are viewed positively by state eligibility and ICA staff. The programs are considered an important part of the patchwork quilt of services offered to low-income Medicare beneficiaries. The QMB program is seen as affording basic protection against out-of-pocket medical expenses and reducing financial barriers to care. The SLMB program is viewed primarily as an income assistance program that pays the monthly Medicare Part B premium ($43.80 in 1998).

The most successful state programs have developed outreach messages with two basic themes:

- The QMB/SLMB programs can put much needed money back into a family's pocket to pay for other essentials, such as prescription drugs, food, and rent.

- The QMB/SLMB programs provide a benefit that people have earned by working hard all their lives; it is not a government "handout."

State Medicaid eligibility and ICA officials reflect the perspectives of those who have day-to-day interaction with Medicare beneficiaries, and who have first-hand knowledge of the way the QMB/SLMB programs help beneficiaries. The officials we interviewed, though universally supportive of the program, acknowledged that their views do not necessarily reflect the "fiscal or policy views" of other officials within the Medicaid agency. They felt that Medicaid
tends to underfund administration of the program. They felt that, with additional resources for outreach and with smaller caseloads, they could be more effective.

**Theme #2: Grassroots Outreach Appears to be the Most Effective Approach to Educating and Informing People About the Programs.**

Based on the interviews, we found that the ICAs, through links with local agencies, play a critical role in disseminating information about the QMB/SLMB programs. They also play an important role in screening for eligibility, helping fill out applications, making copies of documentation, and mailing and tracking completed applications. One ICA official declared that ICAs are the "one source that do seem to really help get things resolved and really understand the system." Whether there are problems with Medicaid recertification, tracking down errant applications, or simply providing envelopes and postage stamps to mail in applications, ICA staff and volunteers provide invaluable assistance. In this era of complex health care choices, the counselors offer information about options, both public and private. Nevertheless, in most states, there is a lack of formal coordination between the ICAs and Medicaid agencies.9 (See the Massachusetts "best practice spotlight" for an example of how one state's aging network has helped with QMB/SLMB outreach.)

State and local agencies are grappling with a common issue--how to craft a message and select a medium to reach those who are potentially eligible but not enrolled in the QMB/SLMB programs. Many states reported particular difficulties in enrolling "hard to reach" populations.

- In California, for example, agencies have recruited outreach workers from ethnic communities who speak the same language and have the same cultural background as those who are potentially eligible. They found that paid advertising in ethnic and local newspapers worked better than free, public service radio announcements. They remain frustrated, however, by the lack of interest and trust in the program, which is perceived as a "welfare" program.

- New Mexico currently is exploring ways to increase participation among the Navajo population; this population typically has relied on Indian Health Service providers and has not felt the need for supplemental coverage.

Several state eligibility and ICA staff asserted that national leadership in developing a QMB/SLMB outreach strategy would be beneficial to states and local agencies; moreover, it would most likely have spillover effects onto other programs for low-income Medicare beneficiaries. One official envisioned a public-private partnership to develop an approach for

---

9 This is similar to the finding by McCormack et al. (1996) in their evaluation of state ICA programs: “The strongest need for coordination lies among state DOAs [departments on aging], DOIs [departments of insurance], and Medicaid Agencies. The organizations should be aware of each others’ activities in order to support an active referral network. Although this feature is instrumental to program effectiveness, it was one of their weaker areas.”
BEST PRACTICE SPOTLIGHT: Massachusetts

Helping Beneficiaries Through Local Aging Networks

The key to Massachusetts' high enrollment rate appears to be the extensive outreach efforts by the aging community, coupled with aggressive assistance in the enrollment process, and clear messages about the benefits accruing from coverage. The ICA program--known as SHINE, Serving Health Information Needs of Elders--subcontracts with 17 aging organizations in the state, which, in turn, work with more than 400 agencies (including hospitals, libraries, disability organizations, multicultural civic organizations, and home health agencies). The sole function of the SHINE program is to help with insurance and managed care choices. The program has no official relationship with Medicaid, nor does it perform any concrete outreach specifically for the QMB/SLMB programs. The program performs "integrated outreach" for all options, and includes information about the QMB/SLMB program in all materials, training, and counseling efforts.

The SHINE program uses state and townwide Census data to identify the target population. Each town has a council on aging that does specified outreach for the low-income population. They find that identification is the easy part; enrollment is harder. The SHINE program assists in many ways with the enrollment process. In addition to helping beneficiaries fill out the application, SHINE staff explain what documentation is required and provide a checklist for documentation, make copies of the forms, provide postage and envelopes, and will even call and check on the status of applications at Medicaid. And, if the difference does not show up in the Social Security check within one to two months, they will follow up with Medicaid or Social Security. The state uses a single application and screening process for Medicaid, QMB, and SLMB coverage.

The SHINE staff reported that, because medical assistance still carries a welfare stigma, they try to present the QMB/SLMB programs as a way to raise beneficiaries’ income. The message to beneficiaries is that $43.80 per month (the amount of the Medicare Part B premium in 1998) is a "big deal"; it raises gross annual income by 4.5 percent, and “if you are eligible for the benefit, you should get it.” Another incentive is that the savings can be used toward more comprehensive coverage. For SLMBs, in particular, this is important, given the limited benefit to which they are entitled. For example, with the $43.80 savings from the Part B premium, a SLMB beneficiary can buy a core Medigap policy for about $50. Such a policy covers catastrophic hospital care, Part B cost-sharing, and the blood deductible; it does not cover deductibles for Part A and B, skilled nursing facility days, foreign travel, and prescription drugs. SHINE counselors also help low-income Medicare beneficiaries to evaluate managed care choices and to enroll in the state's new pharmaceutical assistance program for older persons.
marketing the program and to improve informational materials (for example, videos). This type of initiative, in the view of this official, would produce better materials than individual agencies alone can afford.\textsuperscript{10}

\textbf{Theme #3: States with More Generous Medicaid Eligibility Standards for Older Persons and Persons With Disabilities Have Higher QMB/SLMB Enrollment Rates.}

Eleven states--including Massachusetts and Mississippi--have expanded Medicaid eligibility for poverty-level aged and disabled Medicare beneficiaries to provide full Medicaid benefits in addition to the “buy-in.” We found an association between more generous state Medicaid eligibility thresholds and higher QMB/SLMB enrollment rates. The expanded Medicaid benefit, which is more attractive and more valuable to beneficiaries than the QMB benefit alone, encourages low-income older persons to seek assistance.

- Mississippi expanded Medicaid eligibility for older and disabled persons to 100 percent FPL at the same time eligibility for pregnant women was raised. The state undertook a comprehensive media campaign about the expanded coverage. This is one of the keys to Mississippi’s success, as revealed in the "best practice spotlight."

- California supplements the federal SSI limit, thereby raising the income threshold for SSI eligibility above poverty, which automatically entitles more Medicare beneficiaries to full Medicaid coverage. This includes not only premium and cost-sharing protections, but also expanded benefits.

- Florida raised the eligibility cut-off for older and disabled persons to 100 percent FPL and raised the income disregard by $1,000 for the QMB/SLMB programs (to align the assets limit with the requirements for Florida’s Medicaid program). In addition, Florida makes extensive use of the medically needy spend-down provision to enable people to qualify for full Medicaid coverage.

- In 1999, Minnesota expects HCFA approval to implement a new Medicaid-funded prescription drug benefit for older persons with incomes up to 150 percent FPL. When the state promotes this new benefit, it intends also to raise awareness about the QMB, SLMB, and QI-1 programs. The state expects the availability of the new prescription drug program to increase enrollment in these other programs.

\textsuperscript{10}The new Children’s Health Insurance Program (CHIP) is facing similar issues. With approximately 40 percent of uninsured children who are Medicaid-eligible but not enrolled (American Academy of Pediatrics 1998), states are exploring new and creative mechanisms for conducting outreach, screening, and enrollment. One eligibility official remarked that the state is spending $750,000 on outreach for CHIP; meantime, outreach for QMB/SLMB remains seriously underfunded.
BEN TACTICE SPOTLIGHT: Mississippi

Enhancing the QMB Benefit Through Medicaid Eligibility Expansion

The secret to Mississippi’s success was a Medicaid eligibility expansion for poverty-level aged and disabled (PLAD) individuals. The state legislature raised Medicaid financial eligibility to 100 percent FPL for poverty-level aged and disabled persons at the same time eligibility was expanded for pregnant women. Thus, all elderly and disabled individuals in Mississippi who are living in poverty and who meet the resource limits are eligible for full Medicaid benefits in addition to Medicare premium and cost-sharing payments.

The eligibility expansion was coupled with a multifaceted outreach effort to inform beneficiaries of the availability of expanded coverage. The state conducted a media blitz for all Medicaid expansion populations, participated in town meetings, outstationed eligibility workers, distributed brochures, and produced mass mailings. The ICA in Mississippi has 80 volunteers across the state’s 82 counties who provide information and make referrals. At least 75 percent of the contacts are related to health insurance options, although information also is available on such issues as housing, transportation, case management, and home-delivered meals.

The state had targeted 40,000 new enrollees under the PLAD expansion and, as a measure of its success, exceeded its target by 10,000. The PLAD expansion offers coverage of prescription drugs to all poverty-level aged and disabled persons (among other Medicaid benefits); it is widely believed that the availability of prescription drug coverage attracts a large number of applicants, some of whom are found to have incomes above the poverty level. When applicants are not eligible for the PLAD expansion, they automatically are reviewed for SLMB coverage. Also, those who do not meet the more restrictive Medicaid resource requirements may be eligible for QMB-only coverage (that is, premium and cost-sharing protections but not full wraparound benefits).
We conclude that QMB/SLMB enrollment is likely to be higher in states where the Medicaid benefits are more generous--in other words, where beneficiaries are more likely to receive full Medicaid benefits in addition to Medicare premium and cost-sharing protections. It is not clear, however, whether this is a function of greater beneficiary awareness of the more comprehensive benefits, a higher perceived value placed on the benefits, or some other factor. This finding is consistent with earlier research on factors associated with participation in the SSI program; participation rates among elderly individuals were directly related to the benefit level to which the individual was entitled (Coe 1985).

Theme #4: The Lack of Integrated Financial Protections for Low-income Medicare Beneficiaries Often Results in Fragmentation of Health Care Benefits and Duplication of Coverage.

Eligibility workers and health insurance counselors report they strive to identify the full array of programs and services that can assist low-income Medicare beneficiaries to free up more resources for covering out-of-pocket health care costs. They attempt to assemble a package of benefits that provides the most generous financial protections available in the community where the beneficiary lives. These programs include: supplemental prescription drug coverage through a state program or through a pharmaceutical manufacturer; Medicare managed care; or other assistance, such as food stamps, energy assistance, or housing subsidies.

What typically brings people into the local Medicaid office or ICA is financial distress. Perhaps they have large unpaid medical bills, the premium on their Medigap policy has just been raised, or they cannot afford their prescription drug costs, along with rent and food. Many health insurance counselors and Medicaid eligibility workers believe it is risky to advise people to drop their private Medigap policy because Medicaid benefits can change as a result of federal and/or state budget crises. No one can promise that these programs will remain as they currently exist. And Medicare is changing as well, with the new health plan options offered under Medicare+Choice and with the entry and exit of health plans. In addition, some Medicare beneficiaries rely on Medigap premium payments to qualify for full Medicaid benefits by “spending down” onto the state “medically needy” program.

For those persons with only QMB/SLMB assistance, Medigap policies provide a cushion against prescription drug costs and other uncovered health care, despite the financial hardship the monthly Medigap premiums may cause. For low-income beneficiaries and the people who try to help them, this is a "catch-22" caused by the lack of integrated coverage through a single program.

---

11Selected pharmaceutical manufacturers provide "prescription drugs free of charge to physicians whose patients might not otherwise have access to necessary medicines" (PhRMA 1998). Each manufacturer designates eligibility criteria for the program and decides which drugs are offered.
Theme #5: Structural Gaps in Eligibility and Benefits Limit the Financial Protections Available to Low-income Medicare Beneficiaries.

The lack of integrated financial protections results not only from fragmentation of health care benefits (as discussed in Theme 4), but also from gaps in eligibility and benefits. Many low-income Medicare beneficiaries are not eligible for Medicaid protections, and even among those who are eligible, there are significant gaps in coverage. These gaps result, in large part, from restrictions on eligibility that have been designed to limit the fiscal impact of the QMB/SLMB programs. While recognizing these fiscal concerns, those we interviewed identified a number of areas where eligibility restrictions present difficulties for both beneficiaries and those making eligibility determinations.

Gaps in eligibility and benefits include:

- **Income eligibility for full premium payment limited to 120 percent FPL.** Both anecdotal and empirical evidence suggest that those with incomes up to 200 percent FPL have out-of-pocket outlays for health care costs equivalent to costs for those currently eligible for the SLMB program. In 1997, near-poor Medicare beneficiaries (100 to 125 percent FPL) spent about 23 percent of their income on health care, on average, whereas other low-income beneficiaries (126 to 200 percent FPL) spent 22 percent (Gross et al. 1997).

- **Retroactive eligibility for SLMBs but not for QMBs.** Most people apply for Medicaid in times of financial distress. SLMB eligibility may be screened for the month of application, as well as three months retroactively (HCFA 1996). This can result in immediate savings of $175 on Medicare Part B premiums. In contrast, QMB eligibility usually becomes effective the month after eligibility is determined (HCFA 1996). Thus, a Medicare beneficiary who is hospitalized and then found to be eligible for QMB coverage will not receive assistance with premiums, deductibles, and coinsurance until after eligibility is determined, resulting in a liability of $764 for the hospital deductible (in 1998), as well as other associated costs of the hospital episode.

- **Restrictive asset limits.** The perception of whether the QMB/SLMB asset limits are a barrier varies considerably across the country. In general, however, the consensus was that the asset limits should be raised. Many Medicare beneficiaries are extremely poor, according to one official, yet they have resources that disqualify them from coverage (such as life insurance or modest savings). Another official speculated that if people are allowed to retain a higher level of assets, they will have more resources that enable them to be more active, which may keep them healthier longer (and lower their long-term medical care costs).

---

11 The Balanced Budget Act of 1997 recently extended full premium payments for Medicare beneficiaries with incomes from 120 through 135 percent FPL (known as Qualifying Individuals). However, this program had not been implemented by most states at the time of the interviews. Moreover, the program is funded under a federal block grant on a first-come, first-served basis, and is not an entitlement. As of November 1998, HCFA’s Third Party Premium Billing File reported 14,189 QI-1s.
• **Lack of outpatient prescription drug coverage.** QMB and SLMB beneficiaries do not receive outpatient prescription drug coverage through the QMB/SLMB programs. This is the single biggest gap in medical care coverage for low-income Medicare beneficiaries, as reported in the interviews.13 (Some beneficiaries may receive prescription drug coverage through employment-based retiree health plans, through the purchase of a private supplemental Medigap policy, through enrollment in a Medicare managed care plan that offers such coverage, or through Medicaid if they are eligible for full benefits). Fourteen states (such as Massachusetts and New York) offer pharmaceutical coverage for low-income older individuals (Gross and Bee 1999). Other states counsel clients to seek assistance through their physicians directly from pharmaceutical manufacturers (PhRMA 1998). In any event, these arrangements introduce further variations and inequities across the country.

• **Lack of coverage for deductibles and coinsurance for SLMBs.** Several state officials commented that they wished the benefits for SLMBs would be expanded to the level of QMB benefits, because these populations have similar health care needs and because SLMBs are not in a significantly better financial position than QMBs to pay out-of-pocket medical costs.

Because of these gaps in eligibility and benefits, low-income Medicare beneficiaries incur large out-of-pocket expenditures for health care, which are disproportionately higher in relation to their income than those incurred by middle- or high-income persons. Although expansion of eligibility and benefits under the QMB/SLMB programs would have federal and state fiscal impacts, the burden of out-of-pocket medical expenses on low-income Medicare beneficiaries cannot be ignored.

**Theme #6: Gaps in the Government “Safety Net” Occur Both Among Programs and Over Time.**

In addition to structural fragmentation in eligibility criteria and covered benefits, we found a lack of integration within the eligibility determination process. Although some states use a computer system that makes an automatic determination of QMB/SLMB eligibility, in most states, the Medicaid application process is not designed to screen automatically for QMB/SLMB eligibility, either at the time of the initial application or when an individual’s circumstances change. For example:

- In Tennessee, applicants are advised to write on the application if they are applying for the QMB or SLMB programs.

- In Michigan, ICA staff are instructed to write in red ink at the top of the application, "Screen for QMB/SLMB."

---

13 Other benefit gaps cited in the interviews include lack of coverage for vision services and dental care.
• In New York, individuals must apply specifically for the QMB program. Although the state uses the same application for full Medicaid and QMB coverage, in some counties, the same caseworker does not necessarily review the application to determine eligibility for full Medicaid or QMB coverage.

• In Minnesota, when MinnesotaCare beneficiaries become Medicare eligible, they are no longer eligible for MinnesotaCare. There is no automated system in place to transition eligible beneficiaries to QMB/SLMB coverage.

Once individuals are enrolled in the QMB/SLMB programs, recertification is conducted annually to determine continued eligibility. States begin notifying beneficiaries several months before they are required to recertify their eligibility; this is done to minimize the number of beneficiaries whose coverage is terminated. Lapses in buy-in coverage are considered annoying and troublesome for both the state and the beneficiary. If an individual fails to recertify, the Medicare Part B premium will be taken out of the person’s Social Security check. Beneficiaries usually discover that their buy-in has been terminated when their Social Security check is reduced by the amount of the Part B premium ($43.80 in 1998). It then takes several months to restore the buy-in status for the beneficiary. ICA officials noted that they regularly receive inquiries from beneficiaries who do not understand the legal language of the recertification letter and consequently ignore the letter. The ICA staff noted that it is a time-consuming process to reinstate the benefits. More straightforward language about the consequences of inaction was recommended, such as, "If you do not send back this form, we will stop paying your Part B premium."

Concerns also were expressed about those losing their SSI eligibility. In some states, there is no automatic referral between SSI and Medicaid to ensure seamless health care coverage. Although states are required to send letters to this population, alerting them that they may be eligible to continue Medicaid benefits, not all states systematically follow up to determine whether beneficiaries are eligible for Medicaid under another category such as QMB or SLMB. However, some states, like New York, continue Medicaid coverage until a separate determination can be made.

Theme #7: The Eligibility Determination Process is Overly Complex, Resulting in Confusion Among Medicaid Beneficiaries and Medicaid Eligibility Workers.

Anecdotal evidence offered in the interviews supports the notion that the eligibility determination process is a major barrier to enrollment. The following factors can lead to errors in the eligibility determination process:

• Lack of automated systems to assist in the eligibility determination process.\(^\text{14}\)

\(^{14}\)Additionally, this is compounded by the low priority placed on computer system updates (that is, relative to the millennium problem or welfare reform).
• Lack of knowledge among eligibility workers specifically about the QMB/SLMB programs.

• Lack of consistency across benefit programs (retroactive coverage, asset tests, initial date of coverage).

Taken together, these factors appear to result in a lack of effective targeting of QMB/SLMB benefits to Medicare beneficiaries, either because of inadequate beneficiary education or lack of information about the program among Medicaid eligibility workers.

In addition, most state eligibility and ICA staff believe that the paperwork burden associated with documenting income and resources can be overwhelming for applicants. Some applicants are apprehensive about revealing income or resource information to caseworkers (some have not revealed this information even to their own children). There are at least two reasons why reporting of income and resources may be more of a barrier for QMB/SLMB eligibles than for other Medicaid eligibles. First, QMB/SLMB eligibles may be less accustomed to the public assistance application process. Second, their expected benefit--relative to those applying for full Medicaid or long-term care benefits--is far less; hence, it may not be worth the effort involved.

One of the usual concerns with streamlining the eligibility process is that individuals who are not eligible will erroneously be determined eligible for the program. However, eligibility staff generally believe that the target population for the QMB/SLMB programs accurately reports income and resources. Staff reported during the interviews that fraudulent applications are rare among a relatively healthy but low-income, community-based population.\(^{15}\) If anything, there was a feeling that this population was so fearful of criminal prosecution that they meticulously report financial information. However, one official noted that beneficiaries may understate their unearned income. For example, during the first year of the QMB program in Tennessee, the state relied on a declaration, rather than verification, of income. At the one-year recertification, the state verified income and found that a small proportion had underreported interest income, most likely due to lack of knowledge rather than intentional efforts to understate income. Streamlining the eligibility determination process would reduce the burden on beneficiaries and caseworkers alike. (See the Tennessee “best practice” spotlight for an example of how one state simplified the application process.)

**Theme #8: Obsolete or Incompatible Data Systems Act as Barriers to Effective Outreach and Eligibility Screening and Impede Tracking and Monitoring.**

Medicaid eligibility and ICA personnel provided numerous examples of how their efforts to enroll people in the QMB/SLMB programs are hampered by obsolete data systems.

\(^{15}\)In contrast, there is concern among eligibility workers about fraud and abuse among families seeking nursing home care.
BEST PRACTICE SPOTLIGHT: Tennessee

Introducing the "BEST" Screening Program

Tennessee established a streamlined application process for the QMB/SLMB programs with a one-page, mail-in application and a telephone interview to verify income and resource information. Beneficiaries were not required to visit a local welfare office unless they sought other public benefits (such as food stamps).

The simplified application process was coupled with an intensive effort to educate and enroll people in the QMB/SLMB programs. The Tennessee Association of Legal Services received a grant from the Tennessee Commission on Aging to develop a program to screen elderly consumers for certain public benefits, including QMB/SLMB, and to assist them in applying for such benefits. Known as the BEST program--Benefits Education for Senior Tennesseans--there were three main components: providing education, screening for eligibility, and assisting with the application process. The association developed a computer program that would screen for QMB/SLMB eligibility, based on age, income, and resources. It triggered a print-out, which could be used to help fill out the QMB/SLMB application, or refer people who might be eligible for SSI to Social Security. The association also developed a benefits screening packet that could be used manually by agencies that did not have computers.

The association conducted a series of free training sessions around the state to acquaint people with QMB/SLMB benefits and to explain how to conduct outreach and screening and complete applications. Their strategy was to reach diverse groups that would, in turn, reach the beneficiary. The BEST program focused on training agencies that had daily contact with older persons and their families. Several hundred people attended the trainings and received manuals, hand screening packets, and computer disks. BEST was used by home health care workers who visited people in their homes, legal services offices, agricultural extension agencies, social services agencies, public housing authorities, churches, hospital social services, public health departments, health clinics, Goodwill and Salvation Army organizations, neighborhood centers, and other similar groups and agencies.

A positive spillover effect of the screening process was that the association identified a large number of people who potentially were eligible for SSI. (The association is aware of about 2,400 individuals who were screened for SSI eligibility, but this is based on reports from 21 out of 300 people who conducted BEST screening.) When a potential SSI-eligible was identified, counselors called a 1-800 hotline immediately to "date stamp" the SSI application for retroactive eligibility. SSA would then call the beneficiary to begin the application process. With the benefit of 20-20 hindsight, the association wishes they had collected more information on the effectiveness of the screening process in enrolling QMBs and SLMBs. However, they made a deliberate decision to minimize the paperwork burden so groups could focus on education, screening, and enrollment.
- In Florida, for example, the SLMB program was implemented after the Florida System (the state’s automated Medicaid/welfare eligibility system) was designed. As a result, eligibility for SLMB is coded manually. The worker needs to review income and resources manually, which is time-consuming and prone to error. Moreover, on occasion, the buy-in indicator is not automatically transferred from the Florida System to the Medicaid Management Information System (MMIS), which means that Medicaid does not recognize the eligibility for buy-in purposes.

- In Michigan, system errors resulted in the inadvertent termination of QMB/SLMB coverage for about 7,000 beneficiaries. The beneficiaries received a letter indicating they were no longer eligible for coverage. Unfortunately, the state was unable to recover the names and addresses of those who were inappropriately terminated. Although it mounted a media campaign, the state never found all the beneficiaries who were dropped.

- The Massachusetts system sometimes generates multiple denial letters for programs beneficiaries did not even realize they were applying for. Although there is a single application for Medicaid, QMB, and SLMB, it is not uncommon for a SLMB applicant to receive denial letters for Medicaid and QMB before receiving the letter approving eligibility for SLMB benefits. Although this results in confusion and unnecessary alarm, it is a function of an outdated computer system that cannot be streamlined cost-effectively.

Not only do data system problems hamper outreach and enrollment efforts, they also limit monitoring and tracking efforts. Incompatibilities between federal and state data systems result in discrepancies in the number of QMBs and SLMBs. For example, New York maintains that the number of QMBs and SLMBs is considerably higher than the number reported in the HCFA Third Party Premium Billing File. The state estimates there are about 250,000 QMBs, compared with 168,000 in the HCFA database. In addition to receiving the Medicare buy-in benefits, QMBs in New York receive enhanced benefits for clinical psychology, social work, and podiatry services, so the state is confident about the accuracy of its QMB eligibility indicators for purposes of claims payment.  

Another source of inconsistencies between federal and state data has to do with how the buy-in transaction takes place for SSI beneficiaries. Those on SSI receive full Medicaid benefits as well as QMB premium and cost-sharing protections (known by HCFA as QMB-plus). Texas provides a case in point. Texas indicated that SSI beneficiaries who also received QMB benefits were included in the Part B buy-in category but not in the QMB category. This would add another 208,000 beneficiaries to the 95,000 already reported as Part B QMBs. New Mexico reported that there are approximately 20,000 more QMBs than are shown on the HCFA file.

---

16 Some of these QMBs are not "buy-ins" per se, because they use the Part B premium to spend down onto Medicaid. They are considered QMBs by the state, but not necessarily buy-ins.
Other states indicating that the HCFA numbers seem low are California, Florida, Michigan, Minnesota, and Tennessee, primarily because those receiving QMB-plus benefits (that is, full Medicaid benefits in addition to Medicare premium and cost-sharing) are excluded from the QMB counts.\(^\text{17}\)

This suggests the need for a standard national reporting system, independent of the buy-in file, in which states report the number of QMBs and SLMBs using standard definitions and coding procedures. Such a system is critical to understanding how many beneficiaries truly are enrolled. (The "best practice spotlight" on New Mexico focuses on the story behind the numbers.)

**Theme #9: Coordination with the Social Security Administration is Inconsistent Across States, Resulting in Foregone Opportunities for Outreach to and Referral of Potentially Eligible Beneficiaries.**

States varied substantially in their level of coordination with the Social Security Administration (SSA) in administering the QMB/SLMB programs. Some states, such as Tennessee, consider SSA to be one of its major sources of referrals. SSA refers potential eligibles to the state's hotline to obtain information about eligibility and benefits. In Florida, the state reported that SSA periodically sends information about the QMB/SLMB programs to individuals receiving SSA benefits. The Medicaid agency usually sees a temporary, but substantial, increase in the numbers of applications and inquiries immediately after the mailing.

In other states, there was a perception that SSA does not know whom to refer, and that a uniform screening protocol would be desirable. In a few cases, there was uncertainty about what, if anything, SSA actually does to promote the QMB/SLMB programs (for example, whether mailings are sent, and, if so, to whom). One state noted that neither HCFA nor SSA has a current brochure describing the QMB/SLMB programs.

Why is coordination with SSA important? The SSA is a “point of entry” for new Medicare beneficiaries who turn 65 and become eligible for Medicare and for workers who become disabled and apply for Medicare disability coverage. Those with low incomes may be eligible for QMB/SLMB benefits. The SSA also is responsible for determining eligibility for Supplemental Security Income. As such, the SSA not only has direct contact with the target population, but also has relevant financial information that can be used for outreach to potential eligibles.

Although HCFA has initiated an outreach effort using information from SSA to identify those potentially eligible for QMB/SLMB benefits, implementation has been uneven across states. HCFA gave states the option of downloading this information and conducting their own outreach. If states declined, HCFA produced mailings alerting Medicare beneficiaries that they might be eligible for QMB/SLMB benefits. Among the states we interviewed, however, few that

---

\(^{17}\) For example, Tennessee reported that the state Medicaid program is paying the Medicare Part B premiums for 172,373 individuals in November 1998, including 98,918 who are QMBs or SLMBs and 73,454 who are current SSI recipients (QMB-plus). In contrast, HCFA’s Third Party Premium Billing File indicates the state has 76,233 QMBs and SLMBs.
BEST PRACTICE SPOTLIGHT: New Mexico

The Numbers Don't Tell the Whole Story

Data from HCFA's Third Party Premium Billing File suggest that New Mexico has enrolled about 7,600 QMBs and 2,000 SLMBs--approximately one-fourth of those who potentially are eligible. New Mexico is an “auto accrete” state, which means that Medicare beneficiaries who are eligible for SSI automatically are eligible for full Medicaid and QMB benefits. This transaction takes place independent of the third-party premium billing process. Thus, some QMBs are not reflected on HCFA’s file. The state Medicaid agency estimates that there are about 30,000 QMBs and SLMBs, including 20,000 who receive full Medicaid benefits in addition to financial protections through QMB. In addition, some portion of the 3,000 nursing home residents are QMBs but are not included in HCFA’s numbers. Therefore, it would appear that about 80 percent of those who potentially are eligible actually are enrolled in the QMB/SLMB program (considerably higher than the estimate based on data supplied to HCFA in the third-party premium billing file).

New Mexico utilizes several mechanisms that have been effective in enrolling QMBs and SLMBs. First, the state performs outreach to potentially eligible Medicare beneficiaries on an annual basis. About three years ago, New Mexico conducted an initial mass mailing to all Medicare beneficiaries potentially eligible for QMB/SLMB protection (based on Social Security income). Now, the state contacts new Medicare beneficiaries each year (those turning 64½) to inform them of the benefit. Second, beneficiaries can file an application through local Income Support Division (ISD) offices, senior centers, or other community facilities, although a face-to-face interview at the ISD office is required prior to obtaining benefits. Third, the state uses a one-page application form for the QMB/SLMB program. When applicants go to the ISD office for the interview, they are encouraged to fill out the longer application (six pages) if it appears they may qualify for other benefits such as food stamps. The shorter application initially was developed on a pilot basis, but because it has been so successful, it is now being stocked for wider use.

American Indians are a particularly vulnerable population in New Mexico. Many do not have Medicare Part B, instead relying on services provided through the Indian Health Service. The New Mexico ICA, together with volunteers from other organizations (including AARP), conduct a door-to-door outreach effort to inform older American Indians about the QMB/SLMB programs. A toll-free hotline also is used. This combined outreach program is becoming increasingly successful.
told HCFA they would perform the outreach actually downloaded the data—due to lack of software for the download, lack of resources, or competing priorities. Thus, in some states, neither HCFA nor the state appears to be performing outreach to new Medicare beneficiaries who are potentially eligible. HCFA does not follow up to determine whether states are downloading the data and conducting outreach.

**Recommendations for Improving the QMB/SLMB Programs**

Interviews with state eligibility and ICA officials revealed that the QMB/SLMB programs are valuable to low-income Medicare beneficiaries because they cover some of the health care costs that otherwise would have to be paid out-of-pocket. However, the programs have faced a number of challenges that may have limited their effectiveness in reaching and enrolling the target population. For example, beneficiaries may perceive that the value of the benefit is relatively small. Nevertheless, states that relied on grassroots outreach to educate beneficiaries, or that provided more comprehensive Medicaid benefits (in addition to QMB premium and cost-sharing protections), tended to have higher enrollment.

A major concern that arose during this study is the inaccuracy of administrative data on the number of Medicare beneficiaries receiving QMB and SLMB benefits. The lack of accurate enrollment data is a significant barrier, not only to assessing individual state performance in reaching those who are potentially eligible for the programs, but also in evaluating the effectiveness of the QMB/SLMB programs nationally.

The state officials we spoke with acknowledged that states lack incentives to support the QMB/SLMB programs; consequently, there is a lack of focus on these programs among Medicaid policymakers. States currently are faced with several competing priorities in their Medicaid programs, including implementation of the Children’s Health Insurance Program (CHIP), welfare reform, and Medicaid managed care. These efforts draw agency attention away from the plight of low-income Medicare beneficiaries not eligible for full Medicaid benefits.

- State efforts currently are devoted to the design and implementation of CHIP, with a federal appropriation of more than $20 billion. Federal funding of the new categories of qualifying individuals pales by comparison. For example, states are frustrated with the administrative burden of providing an annual benefit of $12.84 to the QI-2s.

- With the emphasis on welfare-to-work and economic self-sufficiency for AFDC/TANF eligibles, the goal is to reduce dependence on government programs. Eligibility workers need to subscribe to a different paradigm for older individuals. With QMBs and SLMBs, the goal is to overcome their resistance to accepting public assistance.

- Many states continue to concentrate significant resources on restructuring their Medicaid delivery systems within a managed care framework, rather than focusing on enhanced outreach and benefits for low-income Medicare beneficiaries.

---

18 State policymakers and budget officials, whom we did not interview, may have a different perspective.
The current QMB/SLMB programs are complex, as well as fraught with policy and budget tensions due to the lack of a coherent national policy about how to protect low-income older persons against their high out-of-pocket health care costs. It is time to reconsider how our nation will provide adequate financial protections to older Americans.

Based on what we learned from this research, we present four recommendations designed to enhance the QMB/SLMB programs:

1. Better data are required to administer the QMB/SLMB programs.

2. National commitment is required to improve the administration and financing of the QMB/SLMB programs.

3. New approaches are required to enhance outreach and enrollment in the QMB/SLMB programs.

4. More research is needed to understand the impact of the QMB/SLMB programs on health care use and costs over the long term.

**Recommendation # 1: Better Data Are Required to Administer the QMB/SLMB Programs.**

We were unable to determine, with any degree of accuracy, how many people are enrolled in Medicaid as QMBs and SLMBs. The lack of accurate national and state-level data on QMB/SLMB enrollment poses a significant barrier to evaluating the performance of the QMB/SLMB programs.

HCFA's Third Party Premium Billing File understates the number of QMBs and SLMBs in many states because not all QMBs and SLMBs are categorized as such in the file, in particular, SSI beneficiaries who are automatically enrolled in Medicaid and who would be considered QMB-plus. Because of coding subtleties across states, more systematic data collection on the number of QMBs and SLMBs should be a high priority for HCFA. Standardized definitions should be developed to help states categorize dually-eligible individuals, with a special emphasis on obtaining accurate counts of QMBs and SLMBs. More accurate data are essential for improving program planning and outreach efforts.

In addition, states require better data on the number and characteristics of individuals potentially eligible for QMB/SLMB benefits but who are not enrolled. Not a single state we interviewed had this type of information, which is critical for targeting outreach and identifying the level of unmet need. Many offered "speculation" about the characteristics of non-enrolled eligibles, but admitted that the evidence was purely anecdotal. In short, not enough is known about the target population.
Moreover, estimating potential eligibility based on population-based survey data—such as the Current Population Survey or the Medicare Current Beneficiary Survey—can be complex and imprecise for several reasons. Self-reported income data may exclude certain categories of income that are considered in determining QMB/SLMB eligibility. During this study, we learned that many older Medicaid applicants do not consider Social Security as income, often failing to declare it on their applications. In addition, survey data may understate the level of beneficiary resources or assets. Finally, other factors—such as citizenship, immigration status, and permanent state residence—may not be captured in surveys, yet are important considerations in determining eligibility for QMB/SLMB benefits at the state level.

**Recommendation #2: National Commitment Is Required to Improve the Administration and Financing of the QMB/SLMB Programs.**

To recognize the full potential of the QMB/SLMB programs, now is the time to revisit the administration and financing of the programs. We believe that a national commitment is required to improve participation in the QMB and SLMB programs. This can only be done with improved agency coordination and enhanced financing.

The state interviews have shown a lack of coordination among state Medicaid agencies, state ICAs, HCFA, and SSA. In particular, more consideration needs to be given to the appropriate roles of the federal government versus the states in performing outreach and education. HCFA is conducting direct mailings in some states and not in others. In some states, it would appear that no mailings are being done either by the federal government or the states.

Enhancing coordination with ICAs and other community-based organizations is also recommended. A promising concept from the Children's Health Insurance Program is the requirement for outreach agencies to screen and enroll, rather than simply to screen and refer, as has been done in the past. This concept deserves further consideration for the QMB/SLMB programs; implementation, however, could require Congressional action. Local health and aging agencies perform extensive outreach for services, often providing case management as well. Much of their time currently is spent providing assistance with the application process. Is there a way to mobilize their efforts to assist in enrollment, without jeopardizing their role as advocates of the client?

SSA represents an important “point of entry” for this population, and the role of the SSA in educating and referring Medicare beneficiaries to the Medicaid program needs to be clarified, expanded, and made more systematic across states. Demonstrations are proposed in up to five states to assess new program models for SSA to publicize, screen, and take applications for QMB/SLMB benefits.

Many advocates and state officials have recommended that the Social Security Administration take over administration of the QMB/SLMB programs. They suggest that Medicare beneficiaries are familiar with SSA and might feel more comfortable applying at an SSA office rather than at a county public assistance office. Moreover, because new Medicare
beneficiaries have contact with SSA prior to joining the Medicare program, some suggest the SSA could process QMB/SLMB applications more efficiently.

We do not believe that simply turning the administration of the programs over to the SSA will resolve the problem of low participation rates in the QMB/SLMB programs. Raising participation in the QMB/SLMB programs requires coordination with state Medicaid programs and others that have contact with low-income Medicare beneficiaries. For the typical Medicare beneficiary, SSA has access to limited information about income (particularly unearned income) and virtually no information on the beneficiary’s assets and resources. Therefore, SSA would need to collect and process more detailed information on income and resources for Medicare beneficiaries, duplicating many of the functions of state Medicaid staff. Also, SSA offices tend to be less conveniently located than county offices. In a rural state, the nearest SSA office may be 200 miles away, while the county public assistance office may be in a local storefront. In addition, Medicare applications increasingly are being filed through the mail for those who start earning Social Security benefits before they become eligible for Medicare. Therefore, SSA would need to develop new procedures for processing applications and determining eligibility for the QMB/SLMB programs. Finally, SSA has neither the legal mandate nor the funding to assume responsibility for the programs.

Rather than shifting responsibility for the administration of the QMB/SLMB programs, we recommend that federal financing of the programs be strengthened. Options include providing a higher matching rate for QMBs/SLMBs (as is being done for CHIP enrollees) and/or providing additional administrative dollars to states to expand outreach and enrollment efforts. We believe these approaches would increase the financial incentives for states to promote QMB/SLMB participation. Enhanced financing should be combined with efforts to increase beneficiary awareness about the program (Recommendation 3).

Recommendation #3: New Approaches Are Required to Enhance Outreach and Enrollment in the QMB/SLMB Programs.

One barrier to achieving high levels of participation in the QMB/SLMB program is a lack of consensus among the states and federal government on what outreach methods and enrollment procedures work best. For example, some states reportedly found letters from SSA to be an effective vehicle that resulted in many inquiries, whereas others felt most people ignored the letters. Not only was there variability among states, but also within states. One official noted that some eligibility workers have developed screening protocols and checklists to assist in eligibility determination, but others are not nearly as organized or systematic.

Our respondents also discussed the trade-offs associated with using a mail-in versus an in-person application process. On one hand, the mail-in application process may save time and remove the barriers imposed by lack of transportation, mobility limitations, or stigma about applying in a welfare office. Yet, without one-on-one counseling, some respondents noted that there is a great deal of confusion among Medicare beneficiaries about the QMB/SLMB programs. Moreover, a statewide mail-in system may reduce the community presence of the programs and decrease sensitivity to local needs and concerns. Differences of opinions also were expressed.
about the value of a shortened application form for those seeking QMB/SLMB benefits. A trade-off is implicit when states move to a shortened application form for certain programs but not for others. Beneficiaries may receive fewer benefits if they apply for a specific program than if they fill out a longer form that screens for eligibility for multiple programs.

Additional attention should be focussed on the recertification process to assure that QMB/SLMB benefits are not terminated for eligible beneficiaries. We learned that recertification often is confusing to beneficiaries. More straightforward language in the recertification letter would help beneficiaries understand the consequences if they fail to recertify their eligibility. This would provide continuity of financial protections for low-income Medicare beneficiaries, and would reduce the administrative burden on state officials.

State eligibility and ICA officials cited the need for national leadership to develop effective outreach methods and implement QMB/SLMB enrollment and recertification strategies. Although outreach is conducted most effectively at the local level, it is inefficient for each local jurisdiction, or even each state, to develop materials. Respondents recommended that the federal government establish a public-private partnership to develop uniform marketing materials and messages states could use. Special attention should be given to approaches to reaching “hard-to-reach” populations.

Recommendation #4: More Research Is Needed to Understand the Impact of the QMB/SLMB Programs on Health Care Use and Costs Over the Long Term.

Few studies have been conducted about the effect of the QMB program on health care costs and use. Limited findings seem to suggest that elderly Medicare beneficiaries with QMB coverage use more Medicare services and have higher Medicare expenditures than those who are eligible for but not enrolled in the QMB program (Parente et al. 1995; and Neumann et al. 1994). These studies are inconclusive for several reasons. Parente et al. found the health status of QMB enrollees was worse than that of eligible nonenrollees. Higher use by QMBs, therefore, could be a function of higher need (or alternately, deferred medical care and serious unmet need due to insufficient resources), rather than simply a response to lower out-of-pocket costs. In addition, Parente et al.'s study analyzed only one year of Medicare claims data. It is not known whether the increased utilization of Medicare-covered services was a temporary experience or would continue over time.

Previous research incompletely captures the impact of QMB/SLMB enrollment on both Medicare and Medicaid costs. We cannot determine from existing data the cost impacts of QMB and SLMB coverage on the Medicaid program, the benefits of which are jointly funded by federal and state governments. There are several reasons why some state officials with whom we spoke believe that QMB/SLMB coverage may actually curtail Medicare and state Medicaid expenditures over time.

- They theorize that because QMB/SLMB coverage removes financial barriers to care, Medicare beneficiaries' access to timely primary and preventive care is improved. This may lead to future reductions in utilization of hospital inpatient and emergency services.
• In states with Medicaid spend down programs, one hospitalization or medical emergency could make a QMB- or SLMB-eligible Medicare beneficiary eligible for full Medicaid benefits.

• Reducing barriers to acute care for this population may ultimately delay a demand for long-term care, which is largely funded by the Medicaid program.

• By "buying in" to Medicare Parts A and B coverage for low income elderly and disabled beneficiaries, the state Medicaid program is no longer the payer of first resort for providers.

Unfortunately, there are no studies that explore these hypotheses from the perspective of Medicaid costs. Such information is critical to informing policy discussions about the costs and benefits of the programs. Also important to current policy discussions about the QMB/SLMB programs is the role of managed care for dual eligibles--especially within the new Medicare+Choice environment--in improving financial protections for low-income Medicare beneficiaries, while at the same time limiting Medicaid outlays. Finally, the comparative roles of Medigap and QMB/SLMB in protecting low-income Medicare beneficiaries against high out-of-pocket health care costs should be assessed.

Conclusion

This study has challenged us to revise our assumptions about the QMB and SLMB programs. We learned that these programs are generally viewed positively by state Medicaid eligibility staff and ICA officials and are considered an important dimension of state efforts to protect low-income older and disabled persons. These perspectives should reassure policymakers of the value of this program to low-income Medicare beneficiaries.

We also learned that federal and state enrollment data for the QMB and SLMB programs are seriously unreliable and that the definitions across states are not standardized. Better data and improved computer systems are required to effectively administer the QMB and SLMB programs.

According to those we interviewed, administration of the programs remains underfunded and a low priority at both the national and the state levels. Federal leadership is recommended to develop national QMB and SLMB outreach strategies and to reduce program barriers among federal and state agencies in the administration of the QMB and SLMB programs. Current efforts to reform Medicare provide an ideal opportunity to consider how best to protect low-income Medicare beneficiaries from burdensome out-of-pocket medical costs. More effort needs to be devoted to bridging the existing gaps between Medicare and Medicaid.
References


# Appendix 1: Medicare Cost-Sharing Requirements, 1998

<table>
<thead>
<tr>
<th>Insurance</th>
<th>Service</th>
<th>Benefit</th>
<th>Medicare Payment</th>
<th>Beneficiary Liability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A</strong></td>
<td>Hospitalization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>First 60 days</td>
<td>All but $764</td>
<td>$764</td>
<td></td>
</tr>
<tr>
<td></td>
<td>61st to 90th day</td>
<td>All but $191/day</td>
<td>$191/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td>91st to 150th day</td>
<td>All but $382/day</td>
<td>$382/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Beyond 150 days</td>
<td>Nothing</td>
<td>All costs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled Nursing Facility Care</td>
<td>First 20 days</td>
<td>100% of approved amount</td>
<td>Nothing</td>
</tr>
<tr>
<td></td>
<td>Additional 80 days</td>
<td>All but $95.50/day</td>
<td>Up to $95.50/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Beyond 100 days</td>
<td>Nothing</td>
<td>All costs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Health Care</td>
<td>Unlimited as long as beneficiary meets</td>
<td>100% of approved amount for services; 80% of approved amount for durable medical</td>
<td>Nothing for services; 20% of approved amount for durable medical equipment.</td>
</tr>
<tr>
<td></td>
<td>Medicare requirements for home health benefits.</td>
<td>approved amount for durable medical equipment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice Care</td>
<td>For as long as doctor certifies need.</td>
<td>All but limited costs for outpatient drugs and inpatient respite care.</td>
<td>Limited cost-sharing for outpatient drugs and inpatient respite care.</td>
</tr>
<tr>
<td><strong>Part B</strong></td>
<td>Medical Expenses</td>
<td>Unlimited services if medically necessary, except for the services of independent physical and occupational therapists.</td>
<td>80% of approved amount (after $100 deductible); 50% of approved amount for most patient mental health services; up to $720 a year for independent physical and occupational therapy.</td>
<td>$100 annual deductible; 20% of approved amount after deductible; charges above approved amount; 50% for most outpatient mental health services; 20% of first $900 for each independent physical and occupational therapy and all charges thereafter each year.</td>
</tr>
<tr>
<td></td>
<td>Outpatient Hospital Services</td>
<td>Unlimited if medically necessary.</td>
<td>Medicare payment to hospital based on hospital costs.</td>
<td>20% of whatever the hospital charges (after $100 deductible).</td>
</tr>
<tr>
<td></td>
<td>Laboratory Services</td>
<td>Unlimited if medically necessary.</td>
<td>Generally 100% of approved amount.</td>
<td>Nothing for services.</td>
</tr>
<tr>
<td></td>
<td>Home Health Care</td>
<td>Unlimited as long as beneficiary meets</td>
<td>100% of approved amount for services; 80% of approved amount for durable medical equipment.</td>
<td>Nothing for services; 20% of approved amount for durable medical equipment.</td>
</tr>
<tr>
<td></td>
<td>Medicare requirements.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Monthly Premium**

- **Part A**: Most beneficiaries do not have to pay a premium. For those with fewer than 30 quarters of Medicare-covered employment, $309/month; $170/month with 30-39 quarters.
- **Part B**: $43.80/month (premium may be higher for late enrollment).


**NOTES**

1) This table presents cost-sharing for traditional fee-for-service Medicare only.
2) No catastrophic limit on outpatient costs.
Appendix 2: Definition of Dual Eligibles

**Dual Eligibles** - Individuals entitled to Medicare (at least hospital insurance under Part A) and eligible for some category of Medicaid benefits. The following information describes the various categories of individuals who, collectively, are known as dual eligibles.

1. **Qualified Medicare Beneficiaries (QMBs)** - Individuals entitled to Part A of Medicare, with income not exceeding 100% of the Federal poverty level, and countable resources not exceeding twice the SSI limit. QMBs may be eligible for full Medicaid or may have Medicaid eligibility limited to payment of Medicare Part A and Part B (supplementary medical insurance) premiums and Medicare cost-sharing (deductibles and coinsurance) for Medicare services provided by Medicare providers. Federal financial participation (FFP) equals the Federal medical assistance percentage (FMAP).

   A. **QMBs without other Medicaid (QMB Only)** - Individuals entitled to Part A of Medicare, with income not exceeding 100% of the Federal poverty level, and resources not exceeding twice the SSI limit. Eligibility for Medicaid is limited to payment of Medicare Part A and Part B premiums and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers. FFP equals FMAP.

   B. **QMBs with Medicaid (QMB Plus)** - Same as A. above and eligible for full Medicaid benefits for Medicaid services provided by Medicaid providers. FFP equals FMAP.

2. **Non-QMBs** - Individuals entitled to Medicare and eligible for full Medicaid benefits, but not as a QMB (typically, medically needy individuals who have to spend down income to qualify). Medicaid benefits are for Medicaid services provided by Medicaid providers, but only to the extent that the Medicaid rate exceeds any Medicare payment for the service covered by both Medicare and Medicaid. Payment of Medicare Part B premiums is optional. FFP equals FMAP.

3. **Specified Low-Income Medicare Beneficiaries (SLMBs)** - Individuals entitled to Part A of Medicare, with income above 100%, but not exceeding 120% of the Federal poverty level, and resources not exceeding twice the SSI limit. Eligibility for Medicaid benefits is limited to payment of Medicare Part B premiums. FFP equals FMAP.

4. **Qualified Disabled and Working Individuals (QDWIs)** - Individuals entitled to purchase Part A of Medicare (Medicare benefits lost because of return to work), with income below 200% of the Federal poverty level, and resources not exceeding twice the SSI limit, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums. FFP equals FMAP.

5. **Qualifying Individuals 1 (QI1s)** - Effective 1/1/98-12/31/02. Individuals entitled to Part A of Medicare, with income above 120%, but less than 135% of the Federal poverty level, resources not exceeding twice the SSI limit, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums. FFP equals FMAP at 100%, but is annually capped. Entitlement of individuals is limited by the availability of the capped allocation.

6. **Qualifying Individuals 2 (QI2s)** - Effective 1/1/98-12/31/02. Individuals entitled to Part A of Medicare, with income at least 135%, but not exceeding 175% of the Federal poverty level, resources not exceeding twice the SSI limit, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to partial payment of Medicare Part B premiums. FFP equals FMAP at 100%, but is annually capped. Entitlement of individuals is limited by the availability of the capped allocation.

### Medicaid Eligibility Criteria: State Choices for Low-Income Elderly, 1998

<table>
<thead>
<tr>
<th>State</th>
<th>Eligibility up to 100% FPL (1)</th>
<th>Medically Needy Coverage for the Elderly (2)</th>
<th>SSI Program Standard (3)</th>
<th>State Supplements SSI Payments (4)</th>
<th>1915(c) Waiver Targets Elderly (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Alaska</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Arizona</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>(6)</td>
<td></td>
</tr>
<tr>
<td>Arkansas</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Colorado</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Connecticut</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Delaware</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>District of Columbia</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>(8)</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Hawaii</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Idaho</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Kansas</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Maine</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Maryland</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Missouri</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Montana</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebraska</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Nevada</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>North Carolina</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>North Dakota</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Ohio</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oklahoma</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>South Carolina</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vermont</td>
<td>Yes (12)</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Virginia</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wyoming</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(continued)
Appendix 3 (continued)

Notes:

(1) Health Care Financing Administration, Commerce Clearing House, and personal communications v states. As of 1996, these states have exercised the option to raise the income threshold for Medicaid eligibility for the elderly to 100 percent of the federal poverty level (FPL).

(2) Social Security Administration (SSA), State Assistance Programs for SSI Recipients, Baltimore, Jan 1998. States may extend Medicaid coverage to "medically needy" persons, that is, persons who meet categorical requirements for Medicaid but whose income or assets may exceed thresholds. People become medically needy because of their high medical and long term care expenses.

(3) SSA, 1998. States listed determine Medicaid eligibility based on Supplemental Security Income (SSI) program standards. In the other states, known as 209(b) states, SSI eligibility does not guarantee Medicaid eligibility; 209(b) states use more restrictive criteria to determine Medicaid eligibility.

(4) SSA, 1998. States listed provide extra funds to recipients to help them meet needs not fully covered by SSI payments, such as food, shelter, and utilities. These additional cash assistance payments are known as state supplement payments (SSP). SSP levels vary by state; for example, Oregon supplements SSI payments by about $20 per year, whereas California supplements these payments by about $1,900 per year. Payment levels may also vary within a state. A "yes" indicates that the state supplements payments for the elderly who live alone. Some states not indicated here provide SSP to other SSI recipients (e.g., blind, domiciliary residents).

(5) National Association of State Medicaid Directors, Database of 1915(c) Waivers, July 1998, http://medicaid.apwa.org/1915ccht.html. Data are as of July 1998. States listed have been given 1915(c) waiver authority to provide home and community-based care to elderly persons who, without these services, would require institutionalization that would be covered by Medicaid. States may also target groups such as disabled, children, the mentally ill, and others. Eligibility criteria for the waiver and, therefore, enrollment greatly across states.

(6) Arizona has a section 1115(c) waiver. The Arizona Long Term Care System provides services for other elderly persons, known as medically and financially eligible elderly. It pays for either nursing home care or various home community based services.

(7) Waiver applies only to disabled elderly.

(8) Based on personal communication with state's Medicaid office, November 6, 1998. Florida extends to 90% FPL, not 100% FPL, as listed in CCH.

(9) Waiver applies only to elderly (age 62 and above) in assisted housing.

(10) Waiver applies only to frail elderly.

(11) Waiver applies only to frail elderly at home or in group care.

(12) Based on personal communication with state's Medicaid office, November 6, 1998.
Appendix 4: Quality of Data on QMB/SLMB Enrollment

Introduction

This project obtained state-by-state information on QMB and SLMB enrollment (categories 1 and 3 in Appendix 2) for two main purposes: (1) to select a sample of states with high, medium, and low levels of enrollment for the telephone interviews; and (2) to share the data with state officials during the telephone interviews and identify potential data problems. This appendix presents data on QMB/SLMB enrollment by state, and discusses the quality of the data, including data limitations.

Data and Methods

To explore the level of variation in QMB/SLMB enrollment across states, we obtained data from HCFA’s Third-Party Premium Billing File. The file contains information on the number of Part A QMBs, Part B QMBs, Part B SLMBs, and total number of Part B buy-ins (that is, the number of people for whom the state Medicaid program pays the Medicare Part B premium). The Third-Party Premium Billing File is used by HCFA to generate a bill to states for the state portion of the Part B premiums for QMBs and SLMBs and other Part B buy-ins. Data on the number of QMBs and SLMBs are reported by the states to HCFA. HCFA intends that the Part B QMB counts include both the QMB-only and QMB-plus beneficiaries (see Appendix 2 for definitions).

There is no way to determine from the Third-Party Premium Billing File whether QMB beneficiaries have full Medicaid coverage (QMB-plus) or whether they have QMB coverage only (categories 1A and 1B in Appendix 2). In addition, because the data are aggregated at the state level, there is no way to determine whether the enrollees are elderly or disabled. Nevertheless, it is important to present these data in ways that policymakers find meaningful.

We derived state-by-state measures of Part B QMB/SLMB enrollment (as reported in the Third-Party Premium Billing File) in relation to (1) total Medicare Part B beneficiaries in the state and (2) the number of low-income Medicare beneficiaries age 65 and over in the state. Data on the total number of Medicare Part B beneficiaries were obtained from HCFA’s Enrollment Data Base. Data on the number of low-income Medicare beneficiaries were derived by the AARP Public Policy Institute using the March 1996 and 1997 Current Population Surveys and reflect the number of Medicare beneficiaries age 65 and over with incomes at or below 120 percent of the federal poverty level.

Results

According to HCFA’s Third-Party Premium Billing File, 2.7 million Medicare beneficiaries were enrolled in Medicaid as QMBs or SLMBs as of July 1997 (Table 1).
This represents an estimated 7.5 percent of total Medicare Part B beneficiaries and about half of low-income Medicare beneficiaries (up to 120 percent FPL).

There was wide variation across states. Enrollment ranged from a high of 20 percent of all Medicare beneficiaries in Mississippi to less than 1 percent in New Hampshire, Nebraska, and Alaska. Adjusting for the level of poverty among elderly Medicare beneficiaries, we found that enrollment exceeded 100 percent of the estimated number of low-income Medicare beneficiaries in Mississippi and Massachusetts and was less than 5 percent in Rhode Island and Alaska.¹

Data Limitations

At least two factors may result in undercounting the number of QMBs and SLMBs. First, state officials report that the Medicare beneficiaries who qualify for expanded Medicaid benefits (QMB plus full Medicaid, category 1B in Appendix 2) often are not included in the QMB counts, but rather are included in the total Part B buy-in category on the Third-Party Premium Billing File. In most states, the Medicaid Management Information System (MMIS) codes only a single eligibility category, and the more comprehensive category would be coded (that is, full Medicaid benefits), along with the Part B buy-in indicator. Second, some states do not include SSI recipients in the QMB counts provided to HCFA on the Third-Party Premium Billing File. In “auto accrete” states (also known as Section 1634 states), the state enters into an agreement with the Social Security Administration to automatically buy-in for all SSI recipients. Several states reported that if they include SSI recipients in the data transmitted to HCFA for the Third Party Premium Billing File, it delays the effective date of the buy-in. In such cases, SSI recipients will be included in the total buy-in counts, but not in the QMB counts. These two factors can result in substantial undercounts, but to date there has been no systematic effort to determine the extent of the undercount in each state.

Based on our interviews with state eligibility officials, we conclude that it is impossible to determine, with any precision, state-by-state participation in the QMB/SLMB programs. Therefore, readers are cautioned in their interpretation of these data. Given these data limitations, the data should not be used to assess state performance in implementing the Medicaid buy-in programs or to compare participation rates from one state to another.

¹Participation rates can exceed 100 percent, for several reasons: (1) lack of precision of the denominators of 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 age 65 and over; and (3) more generous allowance of income in the eligibility determination process due to income disregards (that is, income not counted in determining eligibility).
### TABLE 1

ENROLLMENT OF QUALIFIED MEDICARE BENEFICIARIES (QMBs) AND SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLMBs), BY STATE, JULY 1997

<table>
<thead>
<tr>
<th>State</th>
<th>Total Number of Medicare Part B Beneficiaries (1)</th>
<th>Number of Low-Income Medicare Beneficiaries Age 65 and Over (2)</th>
<th>Total Part B QMBs and SLMBs (3)</th>
<th>QMBs/SLMBs as a Percent of Total Medicare Beneficiaries Age 65 and Over (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All States</td>
<td>35,744,918</td>
<td>5,261,441</td>
<td>2,672,720</td>
<td>7.5</td>
</tr>
<tr>
<td>Alabama</td>
<td>630,363</td>
<td>128,182</td>
<td>37,993</td>
<td>6.0</td>
</tr>
<tr>
<td>Alaska</td>
<td>33,737</td>
<td>1,252</td>
<td>17</td>
<td>0.1</td>
</tr>
<tr>
<td>Arizona</td>
<td>601,526</td>
<td>85,702</td>
<td>33,456</td>
<td>5.6</td>
</tr>
<tr>
<td>Arkansas</td>
<td>411,412</td>
<td>83,036</td>
<td>25,748</td>
<td>6.3</td>
</tr>
<tr>
<td>California</td>
<td>3,546,345</td>
<td>560,091</td>
<td>409,217</td>
<td>11.5</td>
</tr>
<tr>
<td>Colorado</td>
<td>417,654</td>
<td>40,871</td>
<td>12,514</td>
<td>3.0</td>
</tr>
<tr>
<td>Connecticut</td>
<td>482,612</td>
<td>45,606</td>
<td>44,042</td>
<td>9.1</td>
</tr>
<tr>
<td>Delaware</td>
<td>100,466</td>
<td>12,885</td>
<td>2,388</td>
<td>2.4</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>67,765</td>
<td>20,027</td>
<td>1,744</td>
<td>2.6</td>
</tr>
<tr>
<td>Florida</td>
<td>2,615,301</td>
<td>366,078</td>
<td>225,589</td>
<td>8.6</td>
</tr>
<tr>
<td>Georgia</td>
<td>827,559</td>
<td>146,968</td>
<td>55,468</td>
<td>6.7</td>
</tr>
<tr>
<td>Hawaii</td>
<td>144,389</td>
<td>21,422</td>
<td>4,077</td>
<td>2.8</td>
</tr>
<tr>
<td>Idaho</td>
<td>148,231</td>
<td>15,047</td>
<td>8,863</td>
<td>6.0</td>
</tr>
<tr>
<td>Illinois</td>
<td>1,536,964</td>
<td>155,706</td>
<td>125,739</td>
<td>8.2</td>
</tr>
<tr>
<td>Indiana</td>
<td>795,334</td>
<td>100,243</td>
<td>60,409</td>
<td>7.6</td>
</tr>
<tr>
<td>Iowa</td>
<td>458,908</td>
<td>46,491</td>
<td>41,835</td>
<td>9.1</td>
</tr>
<tr>
<td>Kansas</td>
<td>371,827</td>
<td>43,299</td>
<td>14,964</td>
<td>4.0</td>
</tr>
<tr>
<td>Kentucky</td>
<td>576,037</td>
<td>97,551</td>
<td>37,027</td>
<td>6.4</td>
</tr>
<tr>
<td>Louisiana</td>
<td>560,807</td>
<td>94,611</td>
<td>29,855</td>
<td>5.3</td>
</tr>
<tr>
<td>Maine</td>
<td>198,229</td>
<td>26,155</td>
<td>15,992</td>
<td>8.1</td>
</tr>
<tr>
<td>Maryland</td>
<td>578,683</td>
<td>57,374</td>
<td>47,773</td>
<td>8.3</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>883,181</td>
<td>107,107</td>
<td>121,913</td>
<td>13.8</td>
</tr>
<tr>
<td>Michigan</td>
<td>1,310,738</td>
<td>163,510</td>
<td>51,614</td>
<td>3.9</td>
</tr>
<tr>
<td>Minnesota</td>
<td>611,177</td>
<td>107,030</td>
<td>20,164</td>
<td>3.3</td>
</tr>
<tr>
<td>Mississippi</td>
<td>389,433</td>
<td>69,929</td>
<td>77,872</td>
<td>20.0</td>
</tr>
</tbody>
</table>

**NOTES:**

1. Data on Medicare Part B enrollment are from the HCFA Enrollment Data Base, July 1997.
2. Data on the number of low-income Medicare beneficiaries age 65 and over at or below 120 percent of the federal poverty level were derived by AARP from the March 1996 and 1997 Current Population Surveys.
3. Data on the total number of Part B QMBs and SLMBs are from HCFA's Third Party Premium Billing File, July 1997. The number of QMBs/SLMBs may be undercounted in HCFA's Third Party Premium Billing File because most states do not count those who receive full Medicaid benefits in addition to Medicare cost-sharing protections (QMB plus) as QMBs/SLMBs due to data system limitations.
4. Participation rates in Massachusetts and Mississippi may exceed 100 percent for several reasons: (1) lack of precision of the denominat 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).
<table>
<thead>
<tr>
<th>State</th>
<th>Total Medicare Part B Beneficiaries (1)</th>
<th>Number of Low-Income Medicare Beneficiaries Age 65 and Over (2)</th>
<th>Total Part B QMBs and SLMBs (3)</th>
<th>QMBs/SLMBs as a Percent of Total Medicare Beneficiaries</th>
<th>QMBs/SLMBs as a Percent of Low-Income Medicare Beneficiaries Age 65 and Over (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missouri</td>
<td>805,846</td>
<td>100,424</td>
<td>65,411</td>
<td>8.1</td>
<td>65.1</td>
</tr>
<tr>
<td>Montana</td>
<td>127,389</td>
<td>14,812</td>
<td>10,938</td>
<td>8.6</td>
<td>73.8</td>
</tr>
<tr>
<td>Nebraska</td>
<td>240,544</td>
<td>32,862</td>
<td>2,124</td>
<td>0.9</td>
<td>6.5</td>
</tr>
<tr>
<td>Nevada</td>
<td>198,316</td>
<td>30,092</td>
<td>13,550</td>
<td>6.8</td>
<td>45.0</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>151,586</td>
<td>17,777</td>
<td>1,432</td>
<td>0.9</td>
<td>8.1</td>
</tr>
<tr>
<td>New Jersey</td>
<td>1,123,792</td>
<td>148,126</td>
<td>102,049</td>
<td>9.1</td>
<td>68.9</td>
</tr>
<tr>
<td>New Mexico</td>
<td>207,430</td>
<td>40,816</td>
<td>9,551</td>
<td>4.6</td>
<td>23.4</td>
</tr>
<tr>
<td>New York</td>
<td>2,491,742</td>
<td>399,444</td>
<td>168,694</td>
<td>6.8</td>
<td>42.2</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1,029,266</td>
<td>178,780</td>
<td>45,454</td>
<td>4.4</td>
<td>25.4</td>
</tr>
<tr>
<td>North Dakota</td>
<td>98,995</td>
<td>15,219</td>
<td>1,724</td>
<td>1.7</td>
<td>11.3</td>
</tr>
<tr>
<td>Ohio</td>
<td>1,609,631</td>
<td>192,028</td>
<td>85,207</td>
<td>5.3</td>
<td>44.4</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>473,630</td>
<td>75,771</td>
<td>62,564</td>
<td>13.2</td>
<td>82.6</td>
</tr>
<tr>
<td>Oregon</td>
<td>453,009</td>
<td>41,142</td>
<td>30,247</td>
<td>6.7</td>
<td>73.5</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>1,987,217</td>
<td>263,809</td>
<td>123,490</td>
<td>6.2</td>
<td>46.8</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>156,981</td>
<td>42,685</td>
<td>1,779</td>
<td>1.1</td>
<td>4.2</td>
</tr>
<tr>
<td>South Carolina</td>
<td>510,103</td>
<td>89,628</td>
<td>88,949</td>
<td>17.4</td>
<td>99.2</td>
</tr>
<tr>
<td>South Dakota</td>
<td>112,505</td>
<td>19,350</td>
<td>5,841</td>
<td>5.2</td>
<td>30.2</td>
</tr>
<tr>
<td>Tennessee</td>
<td>757,279</td>
<td>151,532</td>
<td>69,045</td>
<td>9.1</td>
<td>45.6</td>
</tr>
<tr>
<td>Texas</td>
<td>2,053,070</td>
<td>394,938</td>
<td>111,572</td>
<td>5.4</td>
<td>28.3</td>
</tr>
<tr>
<td>Utah</td>
<td>183,403</td>
<td>13,424</td>
<td>11,228</td>
<td>6.1</td>
<td>83.6</td>
</tr>
<tr>
<td>Vermont</td>
<td>81,312</td>
<td>9,109</td>
<td>5,030</td>
<td>6.2</td>
<td>55.2</td>
</tr>
<tr>
<td>Virginia</td>
<td>802,387</td>
<td>156,097</td>
<td>47,559</td>
<td>5.9</td>
<td>30.5</td>
</tr>
<tr>
<td>Washington</td>
<td>672,178</td>
<td>76,597</td>
<td>33,451</td>
<td>5.0</td>
<td>43.7</td>
</tr>
<tr>
<td>West Virginia</td>
<td>320,076</td>
<td>69,313</td>
<td>42,959</td>
<td>13.4</td>
<td>62.0</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>738,626</td>
<td>83,734</td>
<td>23,987</td>
<td>3.2</td>
<td>28.6</td>
</tr>
<tr>
<td>Wyoming</td>
<td>59,927</td>
<td>7,758</td>
<td>2,612</td>
<td>4.4</td>
<td>33.7</td>
</tr>
</tbody>
</table>

NOTES:

1. Data on Medicare Part B enrollment are from the HCFA Enrollment Data Base, July 1997.
2. Data on the number of low-income Medicare beneficiaries age 65 and over at or below 120 percent of the federal poverty level were derived by AARP from the March 1996 and 1997 Current Population Surveys.
3. Data on the total number of Part B QMBs and SLMBs are from HCFA’s Third Party Premium Billing File, July 1997. The number of QMBs/SLMBs may be undercounted in HCFA’s Third Party Premium Billing File because most states do not count those who receive full Medicaid benefits in addition to Medicare cost-sharing protections (QMB plus) as QMBs/SLMBs due to data system limitations.
4. 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 (that is, income that is not counted in determining eligibility).
## Appendix 5: Abbreviations Used in This Report

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFDC</td>
<td>Aid to Families with Dependent Children</td>
</tr>
<tr>
<td>BEST</td>
<td>Benefits Education for Senior Tennesseans</td>
</tr>
<tr>
<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
</tr>
<tr>
<td>DHHS</td>
<td>Department of Health and Human Services</td>
</tr>
<tr>
<td>FPL</td>
<td>Federal Poverty Level</td>
</tr>
<tr>
<td>GAO</td>
<td>General Accounting Office</td>
</tr>
<tr>
<td>HCFA</td>
<td>Health Care Financing Administration</td>
</tr>
<tr>
<td>ICA</td>
<td>Information, Counseling, and Assistance</td>
</tr>
<tr>
<td>ISD</td>
<td>Income Support Division</td>
</tr>
<tr>
<td>MCCA</td>
<td>Medicare Catastrophic Coverage Act of 1988</td>
</tr>
<tr>
<td>MMIS</td>
<td>Medicaid Management Information System</td>
</tr>
<tr>
<td>PLAD</td>
<td>Poverty-Level Aged and Disabled</td>
</tr>
<tr>
<td>QDWI</td>
<td>Qualified Disabled Working Individuals</td>
</tr>
<tr>
<td>QI</td>
<td>Qualifying Individual</td>
</tr>
<tr>
<td>QMB</td>
<td>Qualified Medicare Beneficiary</td>
</tr>
<tr>
<td>SHINE</td>
<td>Serving Health Insurance Needs of the Elderly</td>
</tr>
<tr>
<td>SLMB</td>
<td>Specified Low-Income Medicare Beneficiary</td>
</tr>
<tr>
<td>SSA</td>
<td>Social Security Administration</td>
</tr>
<tr>
<td>SSI</td>
<td>Supplemental Security Income</td>
</tr>
<tr>
<td>TANF</td>
<td>Temporary Assistance for Needy Families</td>
</tr>
</tbody>
</table>