



## ***CMCS Informational Bulletin***

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**DATE:** November 1, 2021

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**SUBJECT:** Opportunities to Increase Enrollment in Medicare Savings Programs

The January 28, 2021 Executive Order on Strengthening Medicaid and the Affordable Care Act directs the Secretary of the Department of Health and Human Services, among other things, to adopt policies consistent with current statute to reduce barriers to Medicaid coverage. This letter describes two ways states can help eligible individuals enroll in the Medicare Savings Programs (MSPs), making health care coverage more accessible and affordable.

MSPs cover Medicare Part A and B premiums and cost sharing for individuals with low income. In 2021, over 10 million individuals were enrolled in an MSP. Moreover, federal law prohibits all Medicare providers and suppliers – not only those that participate in Medicaid – from charging beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) MSP eligibility group for Medicare cost sharing.<sup>1</sup> QMB and other MSPs are essential to the health and economic well-being of those enrolled, promoting access to care and helping free up individuals' limited income for food, housing, and other of life's necessities.

This letter provides information on two opportunities for states to increase enrollment in MSPs. Specifically, this letter focuses on using Medicare Part D Low Income Subsidy (LIS) data to initiate MSP applications, and maximizing MSP Qualifying Individuals (QI) enrollment, for which there is 100 percent federal funding to states for the payment of Medicare Part B premiums.

### **Using LIS data to initiate MSP applications**

The Medicare Part D LIS program (also called Extra Help) pays Medicare Part D prescription drug premiums and cost sharing for over 13 million individuals with low income who meet certain resource criteria. Beneficiaries with full LIS have income less than 135 percent of the federal poverty level (FPL) and resources under \$7,970 for an individual and \$11,960 for a couple in 2021.<sup>2</sup> Because full LIS and the MSPs generally target individuals with income less than 135 percent of the FPL and have the same limit on resources, we expect that most full LIS

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<sup>1</sup> See sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.

<sup>2</sup> These amounts exclude burial expenses. With burial expenses, the amounts are \$9,470 for an individual and \$14,960 for a couple in 2021.

enrollees would also be enrolled in an MSP.<sup>3</sup> However, there are 1.25 million people enrolled in full LIS who are not enrolled in an MSP, despite likely being eligible.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) included several provisions intended to promote the enrollment of LIS applicants into the MSPs. Notably, MIPPA section 113 amended section 1144(c)(3) of the Social Security Act (Act) to require the Social Security Administration (SSA) to transmit data from LIS applications (“leads data”) to state Medicaid agencies. As amended, section 1144(c)(3) of the Act requires that states “initiate” MSP applications using the leads data from SSA. Further, under section 1935(a)(4) of the Act, states must accept the leads data and “act on such data in the same manner and in accordance with the same deadlines as if the data constituted” an MSP application submitted by the individual.

We provided guidance to states on initiating MSP applications based on leads data in [SMDL #10-003](#). In that letter, we noted that states must treat the leads data as if it was an application for MSP benefits submitted directly by the LIS applicant. However, despite our guidance, we have heard reports of state practices that would not meet the statutory standard because they do not meaningfully utilize the leads data and instead put the onus on the individual to separately apply for MSP, including sending a blank MSP application or a letter instructing the applicant how to apply for the MSPs.

In order to meet the statutory standards, set forth by section 1935(a)(4) of the Act, states must promptly act on leads data from SSA to determine eligibility for MSP. States must use the information contained in the leads data to the maximum extent possible and only request additional information that is not contained in the leads data, but is necessary to make an eligibility determination. If an applicant is found to be eligible based on leads data, states must base their effective date of coverage on the date the LIS application was submitted.

Per 42 CFR §435.952(c), when verifying eligibility, including information contained in the leads data, states must not request additional documentation unless information needed by the agency cannot be obtained through data sources available to the state, or the information obtained from such data sources is not reasonably compatible.

MIPPA aligned the MSP and LIS programs more closely by amending section 1905(p)(1)(C) of the Act to increase the resource limit for three MSPs (QMBs, Specified Low-Income Medicare Beneficiaries, and QIs) to the level of the resource limit for full LIS established at section 1860D-14(a)(3) of the Act. However, some statutory differences remain between LIS and MSPs regarding countable income and assets. In addition, in implementing the LIS, SSA adopted several administrative methodological simplifications that are not required federally for MSPs. Therefore, although MSPs and LIS have the same resource eligibility *level*, differences remain in the income and resource eligibility *methodologies* used to determine full LIS status and MSP eligibility in many states. States can further simplify the enrollment process from LIS to MSP and maximize use of the leads data by adopting Medicaid flexibilities to better align LIS and MSP eligibility criteria. For example, using section 1902(r)(2)(A) authority, states can choose to

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<sup>3</sup> Excluding individuals eligible for full LIS because they are full-benefit dually eligible individuals residing in an institution or using Medicaid home and community-based services.

disregard certain income and assets that are counted for MSP but not LIS, such as in-kind support, cash value of life insurance, and burial exclusions. Similarly, using section 1902(r)(2)(A) authority, states can increase the effective income level needed to qualify for MSPs. Finally, states can adopt the family size definition for LIS when determining eligibility for MSPs.

There is significant variation among states in the percentage of LIS enrollees who are likely eligible for an MSP but are not enrolled, from two percent not enrolled to 24 percent not enrolled. A complete state-by-state listing of number and percentage of LIS enrollees who are likely eligible for an MSP but are not enrolled is available in [\*Medicare Part D Low Income Subsidy Program Enrollment and Medicare Savings Program Enrollment\*](#).<sup>4</sup> We encourage states to review this list and assess whether their policies and procedures are compliant, and if they are using the LIS data to the full extent possible to support streamlined enrollment into an MSP.

Additionally, on May 7, 2021, the SSA sent each state a data file of individuals who were likely newly eligible for an MSP but not enrolled. We encourage states to use this information to support beneficiary outreach. Instructions on how states can access that list is available at [https://www.integratedcareresourcecenter.com/e\\_alert/opportunities-support-enrollment-medicare-savings-programs-and-extra-help](https://www.integratedcareresourcecenter.com/e_alert/opportunities-support-enrollment-medicare-savings-programs-and-extra-help).

### **Maximizing enrollment in the Qualifying Individuals group**

States receive 100 percent federal funding for the payment of Medicare Part B premiums for individuals in the QI group. Beneficiaries enrolled in QI are not eligible for other Medicaid program benefits, but coverage of their Medicare Part B premium helps individuals maintain Medicare enrollment and improves economic security. In 2017, the Medicaid and CHIP Payment and Access Commission (MACPAC) estimated that only 15 percent of individuals likely eligible for the QI group are enrolled.<sup>5</sup> Applying that percentage to current enrollment figures means that over 3 million individuals may be paying Medicare Part B premiums despite having income levels that would qualify them for the QI group.

There are federal funds available to support this unmet need. In calendar year 2020, nearly \$200 million of the federal funding available for the QI group remains unspent. We encourage states to implement policies and procedures to help more individuals enroll in QI and unlock this additional federal money.

There are several strategies states may consider to increase QI enrollment. Streamlining MSP enrollment processes, such as use of LIS leads data as laid out above, can help boost enrollment in all MSP groups, including the QI group. States can also accept self-attestation of types of income and resources for which providing documentation may be onerous, such as the cash

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<sup>4</sup> We note that, in making this calculation, we did not include individuals who are enrolled in partial subsidy LIS and may be eligible for MSPs because they live in states that have higher income thresholds for MSP as a result of using authority under section 1902(r)(2)(A) of the Act to disregard income. We also assumed that LIS enrollees who were not enrolled in MSPs did not have significant other resources that are not accounted for in the LIS eligibility determination process, but would be captured by the MSP process.

<sup>5</sup> MACPAC August 2017 Issue Brief, “Medicare Savings Program: New Estimates Continue to Show Many Eligible Individuals Not Enrolled.” Available at <https://www.macpac.gov/wp-content/uploads/2017/08/Medicare-Savings-Programs-New-Estimates-Continue-to-Show-Many-Eligible-Individuals-Not-Enrolled.pdf>.

value of whole life insurance. Outreach efforts such as contacting MSP applicants through multiple modalities (phone calls, e-mails, and letters) to obtain any additional information needed to complete an eligibility determination, as well as partnering with entities such as Aging and Disability Resource Centers (ADRCs), State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), and Centers for Independent Living (CILs) to reach those who may be eligible for QI can also help to maximize enrollment of eligible individuals. Finally, we also remind states of their obligation to comply with the requirements in 42 CFR §435.911 to screen Medicaid applicants for all bases of eligibility, including MSP eligibility, prior to making a final determination of eligibility.

By complying with federal law and maximizing eligibility and enrollment simplifications for dually eligible individuals as discussed here and in previous communications,<sup>6</sup> states can help more individuals with low income enroll in MSPs, which are essential to economic security and access to needed medical care.

### **Technical Assistance**

We look forward to partnering with states to increase enrollment in the MSPs and better serve individuals with low income. If you have any questions regarding the information in this letter or suggestions on improving participation in MSPs, please email [ModernizetheMSPs@cms.hhs.gov](mailto:ModernizetheMSPs@cms.hhs.gov).

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<sup>6</sup> SHO # 20-004, *Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency*. There is also an update to this guidance that was released on August 13, 2021 as SHO #21-002, *Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency*. However, that update does not list the dual eligible enrollment strategies.