Responding to Common Medicaid Unwinding Issues for Dual Eligibles

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This practice tip provides information for legal assistance, elder rights, and aging and disability service providers to identify and resolve common issues impacting people dually eligible for Medicare and Medicaid during Medicaid unwinding.

Issue 1: Individuals Receiving Supplemental Security Income (SSI) are Required to Complete and Submit Renewal Packets or New Applications to Renew Medicaid

SSI-linked individuals in Section 1634 states should not be receiving forms or packets to renew Medicaid coverage because those states agreed to use SSA's approval for SSI benefits as automatic approval for Medicaid. Therefore, SSI recipients in these states should not be receiving renewal packets. Instead, the state just needs to confirm their continued receipt of SSI to renew their SSI-Medicaid.

For non-1634 states or for individuals not receiving SSI, states are obligated to conduct ex parte reviews to determine Medicaid eligibility. Ex parte means states should be using available data sources without requiring action from the individual in their reviews of Medicaid eligibility. Individuals should receive renewal forms and requests for documentation only when ex parte data is insufficient to determine eligibility.

Failure to review eligibility using SSA verification or other ex parte data can create barriers and delays for older adults and people with disabilities because they will then have to fill out forms and submit all income and asset information. This can lead to improper terminations despite continued SSI eligibility or Medicaid eligibility. For people dually eligible for both Medicare and Medicaid, this can also result in the loss of Medicare Savings Program (MSP) eligibility and state payment of Medicare premiums and cost-sharing (see next example).

How advocates can help:

If an individual with SSI receives a renewal packet asking them to reapply or provide extensive documentation of income and assets, contact the Medicaid agency first to provide verification that the individual has SSI. This may help the individual avoid having to submit a full application when the state only needs SSI verification. Request that the agency stamp the received date on any forms or documents submitted. Even if individuals are no longer eligible for SSI, the state must still conduct redeterminations using ex parte data to determine eligibility for other Medicaid programs, like Medicaid aged, blind, and disabled and Medicare Savings Programs, prior to termination.

Issue 2: Older Adults Are Being Improperly Terminated From Medicare Savings Programs (MSPs)

Medicaid plays an important role in making Medicare more affordable for older adults and people with disabilities. When a Medicare enrollee is eligible for Medicaid, Medicaid will pay the individual's Medicare Part B premiums. In addition, Medicare enrollees can be eligible for a Medicare Savings Programs (MSPs).

MSPs are Medicaid programs that pay for Medicare out-of-pocket costs like premiums and co-insurance. MSPs only provide financial assistance; they do not provide benefits coverage. Depending on the income and resource limits of Medicaid and MSPs in a state, some Medicare enrollees are eligible only for an MSP (known as a partial dual); some people are eligible for both Medicaid and an MSP (known as a dual plus); and some Medicare enrollees are eligible only for Medicaid benefits coverage, not MSP (known as a full dual). You can learn more about the MSPs here, including your state's income and resource limits.

Loss of Medicaid and/or MSP eligibility have significant consequences for older adults and people with disabilities and can lead to financial insecurity. Terminated individuals face payment of Medicare premiums and cost-sharing, usually 2-3 months after loss of Medicaid/MSP eligibility. The premiums are usually automatically deducted from SSA retirement, disability, and SSI checks and initial deductions are often for multiple past months of premiums. Individuals who lose Medicaid/MSP may not understand that they will be responsible for Medicare premiums and the sudden decreased check can lead to an inability to pay for essentials, such as housing and food.

Qualified Medicare Beneficiary (QMB) loss is particularly acute as QMB individuals are the lowest income and are often SSI recipients. Individuals who lose QMB can lose state payment of *both* Part A and Part B Medicare premiums. This is because many SSI recipients 65 and over have not worked enough to qualify for free Part A, so the QMB program is also paying their Part A premium. Part A premiums can be as high as $506 a month. With the current federal SSI benefit rate being $914 a month, the deduction of even 1 month of Part A premiums is the loss of 55% of the monthly SSI benefit. Individuals already enrolled in QMB are almost always on a fixed income and unlikely to have experienced a change in income/resources that would make them ineligible. Moreover, even if their income changed, it is likely they would be eligible for another MSP with higher income and resource limits.

How advocates can help:

- If an individual eligible for MSP receives an improper termination notice, advocates should appeal the termination and submit proof of continued eligibility. Additionally, advocates should ask Medicaid to do a manual override to stop data about the improper MSP termination from being transmitted to SSA and prevent premium deductions.
- Make sure that the state uses the improper termination date as the renewal date so that SSA can refund any Medicare premiums that were already deducted.
- Individuals who get terminated from MSP or receive the wrong MSP start date can file an appeal to request the correct MSP start date and should receive retroactive reimbursement for Medicare premiums back to the correct date MSP coverage should have begun. Note that some Medicaid staff may be confused in thinking no QMB retroactive coverage means no retroactive reimbursement.
- Because QMB is not retroactive, advocates should make sure that the state uses the improper termination date as the renewal date so that SSA can refund any Medicare premiums that were already deducted.

Issue 3: Medicare-Eligible Individuals Are Not Being Enrolled in Medicare Special Enrollment Period (SEP)

Many older adults became eligible for Medicare during the pandemic, but may not have enrolled since they were on Medicaid. CMS announced a new Medicare SEP for individuals who missed their Initial Enrollment Period (IEP) but now need to enroll in Medicare. The SEP allows individuals to enroll up to six months from the date of their Medicaid termination notice, and they will not be subject to a Late Enrollment Penalty.

Many individuals may be unfamiliar with the Medicare SEP, and may experience receiving incorrect information from SSA workers that they must wait for their General Enrollment Period (GEP) to enroll in Medicare and are subject to a penalty.

How advocates can help:

- When trying to enroll, advocates and beneficiaries should be prepared to cite the SEP guidance to SSA staff in the Program Operations Manual Systems (POMS) HI 00805.385 Exceptional Conditions Special Enrollment Period (SEP) for Termination of Medicaid Eligibility.
- If an individual was initially told by SSA they could not enroll in Medicare until their GEP, and they're still within the six-month window for the Medicare SEP, they should visit SSA again to enroll with the POMS guidance.
- If an individual is beyond the six-month window, advocates and beneficiaries should request equitable relief from SSA on the basis that they did not enroll in Medicare due to the error, misrepresentation, or inaction of a federal employee. Read more about equitable relief here.

Issue 4: Medicare-Eligible Individuals Told to Apply for Marketplace Coverage when Medicaid Terminates

Some Medicaid notices are informing individuals that they qualify for Marketplace coverage when their Medicaid ends. However, individuals eligible for premium-free Medicare Part A are not entitled to Marketplace subsidies. Individuals that explore Marketplace options will be rejected or may erroneously be granted financial subsidies, leading to potential future repayment at tax time. If individuals erroneously enroll in the Marketplace they also risk missing the Medicare SEP and face lifelong late enrollment penalties. In addition, lack of awareness of the Medicare Special Enrollment Period (SEP) makes this especially confusing.

How advocates can help:

Advocates and assisters should be familiar with the Medicare SEP and refer dually-eligible individuals to SSA to enroll in the SEP or to the State Health Insurance Assistance Program (SHIP).

Issue 5: Dually-Eligible Individuals May Lose Access to Dual-Eligible Special Needs Plans (D-SNPs) or Other Medicare-Medicaid Plan and Their Current Network of Providers and Prescription Drug Plan (PDP)

D-SNPs and other Medicare-Medicaid plans limit enrollment to individuals dually eligible for Medicare and Medicaid. If an individual loses Medicaid eligibility, they cannot remain in the D-SNP plan, potentially losing access to current providers or experiencing delays in scheduled appointments/care. Individuals can choose to join another Medicare Advantage plan or be disenrolled to Original Medicare Parts A and B.

Since the D-SNP is also the prescription drug plan, individuals must also choose a new drug plan. If someone is disenrolled from a D-SNP or other Medicare-Medicaid plan and loses their corresponding Part D prescription coverage through the plan, they have a Special Enrollment Period to enroll in a new prescription drug plan. If they do not affirmatively choose a plan, Medicare will auto-enroll individuals into a benchmark Prescription Drug Plan (PDP). Individuals may use Medicare's LINET Program, which provides temporary drug coverage for dually-eligible individuals until they are enrolled in a new prescription drug plan.

How advocates can help:

- Advocates can refer individuals to SHIP counselors for counseling on other coverage options and Part D prescription drug plans.
- Some D-SNPs offer a "deeming" period that will maintain enrollment in these D-SNPs in the hopes that Medicaid eligibility will be restored in a short amount of time. The deeming period can run from one month to six months depending on the plan's option. Advocates can ask their local D-SNPs about the length of their respective deeming periods to educate enrollees of this protection.
- Medicare enrollees with Medicaid, including an MSP, are automatically enrolled in the "full" Part D Low-Income Subsidy (LIS), which means they are eligible for a zero-premium, zero-deductible PDP with the lowest, fixed copays. It is important for advocates to know that Medicaid termination does not immediately end LIS enrollment. In fact, LIS continues through the end of the year for people whose Medicaid ends prior to July 1 and through the end of the following year for people whose Medicaid ends July 1 or later. For example, LIS continued through the end of 2023 for people whose Medicaid ended prior to July 1, 2023, and through the end of 2024 for people whose Medicaid ended July 1, 2023 or later. For 2024, LIS will continue through the end of 2024 for people whose Medicaid ends prior to July 1, 2024 and through the end of 2025 for people whose Medicaid ends July 1, 2024 or later.

Issue 6: Individuals Are Having Their Medicare Premiums Deducted From Their Social Security Despite Being Approved for Medicare Savings Programs (MSP)

State Medicaid agencies are responsible for paying the Medicare premiums for dually-eligible individuals enrolled in an MSP. The state does this by submitting the payments for the Medicare premiums to the Social Security Administration (SSA), in a process called "buy-in." Some MSP enrollees have reported issues with their state buy-in program, where SSA is deducting their Medicare premiums from their Social Security checks even though they submitted their renewal forms timely and were found eligible for an MSP. In these instances, it appears the state is not fulfilling its obligation under the buy-in agreement with SSA.

How advocates can help:

- Confirm that individuals are properly enrolled in the MSP. If the state incorrectly found them ineligible, then advocates should appeal that decision quickly.
- If an individual is enrolled but still having their premiums deducted, consider reaching out to your state's Medicaid office to determine if the state is actually making payments on the individual's behalf. Sometimes, states will have a particular unit or third-party contractor specifically working on buy-in issues. It would also be helpful to coordinate with other partners to see if this is a systemic issue, and provide that information to the Medicaid office.
- Unfortunately, resolving this issue may be incredibly complicated and could take weeks or even months to get premiums reimbursed. Many MSP enrollees in this situation will experience severe hardship due to the income lost from the premium deduction. Advocates should help individuals apply for assistance to help alleviate this hardship, like increased SNAP, LIHEAP, or other benefits. (See also Issue 2 above for additional MSP advocacy actions).
- Advocates can also send letters to their clients' landlords or mortgage servicers explaining their client's lost income due to a Medicaid error and asking for relief from payments until the Medicare premiums are reimbursed.

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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