

## Expansion Medicaid Transitions Guide

### Introduction

Since its passage in 2010, the Affordable Care Act (ACA) has helped build health security for Americans of all ages through consumer protections and expansion of the Medicaid program. In recent years, Congress has made multiple attempts to repeal the ACA, which would mean a return to times when pre-existing conditions, age, sex, and health status could interfere with access to coverage.<sup>1</sup>

The ACA's Medicaid expansion gives states the option to expand their Medicaid programs, and 34 states including the District of Columbia have decided to do so. The expansion has extended Medicaid coverage to over 15 million low-income adults aged 19-64 with incomes up to 138% of the federal poverty level (FPL).<sup>2</sup> Because the expansion Medicaid population is not permitted to have both Medicare and Medicaid, expansion Medicaid eligibility ends when an individual turns 65 or is otherwise Medicare-eligible.

Drawing on months of surveys with states that have expanded their Medicaid coverage under the ACA (expansion states) and interviews with a selected subset, the [Medicare Rights Center \(Medicare Rights\) previously wrote a report](#) which explores the expansion Medicaid-to-Medicare transition process in 22 states, including challenges and promising practices.

Now, to better assist state advocates nationally who seek to learn about state transition processes, troubleshoot problems their clients are facing, and/or seek improvements to current processes, Medicare Rights—with support from the National Council on Aging (NCOA)—has created this expansion Medicaid transitions guide. The guide includes useful terminology, an overview of the main steps in transition processes, a review of the most common transition pathways, with state-specific examples, and a set of troubleshooting steps to consider when encountering problems.

Ensuring that Medicare beneficiaries receive the benefits they are eligible for is essential as the U.S. population ages and the Medicare and Medicaid landscapes continue to shift. Based on Medicare Rights' findings from 2016, this guide serves as a roadmap that state advocates can use to help residents access Medicare and other insurance programs.

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<sup>1</sup> For example, before the ACA, more than 1 in 5 applications for health coverage from those aged 50 to 64 were rejected. (AARP Public Policy Institute, "Health Costs and Coverage for 50-to 64-Year-Olds" (February 2012), [http://www.aarp.org/content/dam/aarp/research/public\\_policy\\_institute/health/HealthInsurance-Coverage-for-50-64-year-olds-fact-sheet-AARP-ppi-health.pdf](http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/HealthInsurance-Coverage-for-50-64-year-olds-fact-sheet-AARP-ppi-health.pdf).) The ACA also limits the premiums older adults pay to 3 times what younger people pay. Some repeal proposals allow these limits to nearly double or, in some cases, remove all limits. (Congressional Budget Office Cost Estimate, "American Health Care Act" (March 2017), <https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf>.) And eliminating the ACA would also eliminate the Medicaid expansion, which would have a devastating impact on people who are not yet eligible for Medicare, including people with disabilities. (Congressional Budget Office Cost Estimate, "American Health Care Act" (March 2017), <https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf>.)

<sup>2</sup> Kaiser Family Foundation, Medicaid Expansion Enrollment: <https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

## Terminology

Medicaid: A health insurance program for people with low incomes funded through a combination of state and federal dollars. Most people with Medicaid do not pay premiums, copayments, or coinsurance for covered benefits. While Medicaid covers several populations, two types of Medicaid are important for this guide:

- Aged, Blind, and Disabled (ABD) Medicaid: For people who are 65 or older, blind, or have a disability, and who meet state income requirements, which average 73% of the FPL. Most states also include an asset limit. The ABD Medicaid population can be concurrently enrolled in both Medicare and Medicaid, and these individuals are known as dual eligibles.
- Expansion Medicaid: For people who are aged 19-64, have an income below 138% of the FPL, and are not eligible for Medicare. There is no asset limit for this population.

Medicare Savings Programs (MSPs): Programs for people with low incomes funded through a combination of state and federal dollars. All MSPs may have asset limits, though states can choose not to count assets when determining eligibility. Generally, these programs pay for the Medicare Part B premium and may cover other Medicare costs. The MSPs include the Qualified Medicare Beneficiary (QMB) program, Specified Low-Income Beneficiary (SLMB) program, and Qualifying Individual (QI) program.

- Qualified Medicare Beneficiary program: This MSP pays for Medicare cost-sharing (e.g., copayments and coinsurance), in addition to covering Part B premiums. QMB is available to beneficiaries with incomes up to 100% of the FPL, and states can choose to increase this limit.

Extra Help (also known as the Low-Income Subsidy): A federal program that helps pay for some to most of the out-of-pocket costs of Medicare prescription drug coverage (Part D). Extra Help is available to Medicare beneficiaries with incomes up to 150% of the FPL and limited assets.

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

Marketplace (also known as an Exchange): Forums established by the ACA where individuals in need of health insurance can shop for coverage. Marketplace plans include Qualified Health Plans (QHPs) and can include expansion Medicaid plans in states that choose to expand Medicaid. No type of Medicare coverage is sold through the Marketplace.

Medicaid office/Local Department of Social Services (LDSS): State agencies (often located in each county) responsible for addressing the social service needs of people with low incomes. These offices process applications for Medicaid and MSPs.

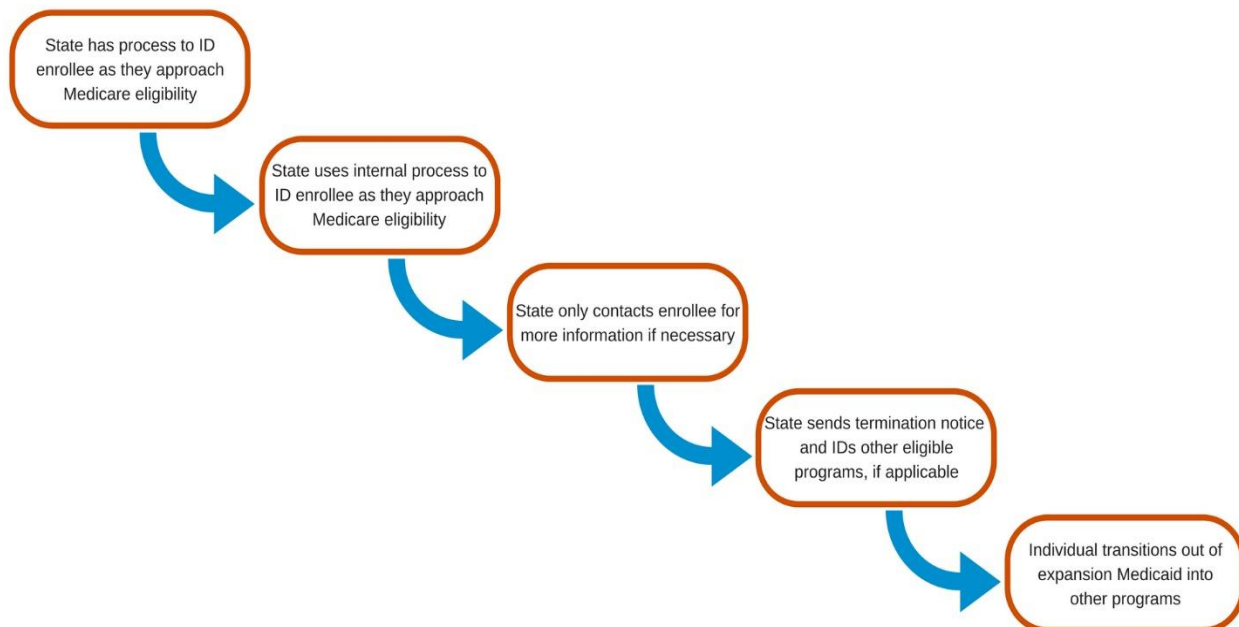
## Three main steps for an individual to receive needed benefits: Identification, Determination, Communication

There are significant differences in how states facilitate transitions from expansion Medicaid to Medicare, as Medicare Rights documents in a previous report. However, state processes can generally be simplified into three main steps: identification, determination, and communication.

1. Identification – State identifies individual transitioning from expansion Medicaid to Medicare. The individual may be turning 65, or they may be under 65 and becoming Medicare-eligible after collecting Social Security Disability Insurance (SSDI) for 24 months.
2. Determination – State screens individual for ABD Medicaid and an MSP. State may use data available through other systems/interfaces to determine individual's income and other information. Some states do not proactively assess individuals for ABD Medicaid or for an MSP.
3. Communication – State contacts individual. This can happen to provide notice that expansion Medicaid benefits are ending, when there is a need for more information, and/or to provide notice of enrollment into new benefits. In their notice about benefits that are ending, some states let individuals know that other benefits may be available, and how to secure them. A state may send various notices, including an expansion Medicaid termination letter, an application for ABD Medicaid and/or an MSP, and educational information related to Medicare enrollment.

Medicare Rights' previous analysis of different state processes suggested an ideal process for transitioning from expansion Medicaid to Medicare and other benefits.

Figure 1: Ideal process map for transitioning expansion Medicaid recipients to Medicare and other benefits



In reality, there is significant variation in how states facilitate transitions from expansion Medicaid to Medicare and other benefits. Variation is a product of different state enrollment processes, as well as a variety of challenges states might face, including systems issues, identification gaps or errors, and problems contacting beneficiaries. What follows is an overview of the main transition pathways that states actually use.

## **Three main ways states process transitions from expansion Medicaid to Medicare**

Expansion Medicaid-to-Medicare transitions usually occur via one of three pathways: Full automation, partial automation, or termination notice only. The following section lays out the defining characteristics of each of these three pathways, along with case studies to demonstrate how the pathways work in reality.

### **Full automation (ex parte)**

States following a full automation protocol for transitions (more commonly referred to as ex parte determinations) use data matching to identify Medicare-eligible individuals and enroll them in or recertify them for benefits. The defining characteristic of ex parte renewals is that the beneficiary is not contacted by state agencies to request information. Instead, the state uses information that it already has access to regarding the beneficiary (either directly or via data-sharing) to determine the individual's eligibility for other benefits.

For expansion Medicaid-to-Medicare transitions, a state will typically request data regarding the beneficiary from another agency, in order to determine the individual's eligibility for ABD Medicaid. However, the sources used to collect information vary by state. For income data, for example, states may look to the Internal Revenue Service (IRS), Social Security Administration (SSA), or other agencies, or use other databases available to them. They can also use data that has been collected for other means-tested benefits programs, such as the Supplemental Nutrition Assistance Program (SNAP).

If the relevant information is available, full automation states should send beneficiaries who are transitioning from expansion Medicaid to Medicare notification of their eligibility for ABD Medicaid and/or an MSP and enroll them in the program(s) if appropriate. States differ in their approaches for handling ineligible individuals and individuals for whom they lack the necessary information to determine eligibility.

- Ineligible individuals – Beneficiary may receive an ineligibility determination and/or application/renewal forms.
- Data unavailable – Beneficiary may be contacted to provide information, or sent application/renewal forms.

As defined, full automation does not require that the state contact the beneficiary for additional information regarding a benefit application. However, states experiencing problems identifying Medicare-eligible individuals through data matching may not determine eligibility for ABD Medicaid or an MSP in a timely manner. In some cases, manual intervention from the beneficiary, their representative, or an advocate may be required to trigger eligibility determination and enrollment.

### State highlight – Louisiana

According to survey respondents from Louisiana, the state uses an ex parte renewal process to assess beneficiaries for ABD Medicaid and/or an MSP. The state Medicaid agency is able to see if someone is aging out of expansion Medicaid (turning 65) at renewal, as well as their Medicare enrollment status.



Before ending any coverage, staff must conduct a review to determine if the individual qualifies for other programs using available data systems. (If necessary, they will reach out to the individual for additional information.) Individuals losing expansion Medicaid should receive a notice telling them whether they are eligible and/or approved for ABD Medicaid and/or an MSP.

### State highlight – Rhode Island

According to survey respondents from Rhode Island, the state uses an ex parte renewal process to assess beneficiaries for ABD Medicaid and/or an MSP. The state Medicaid agency both detects Medicare eligibility and conducts benefit screening through its Unified Health Infrastructure Project (UHIP). This integrated computer system is also responsible for generating notices sent to individuals losing expansion Medicaid.



Unfortunately, due to a number of technical errors with the UHIP system, respondents commented that individuals do not always receive benefit evaluation.

### Partial automation/Application

States following a partial automation protocol for transitions use data matching to identify Medicare-eligible individuals and send them information/applications. The defining characteristic of this pathway is that the state does not attempt to determine the beneficiary's eligibility for ABD Medicaid or an MSP, and to automatically enroll them in these benefits where appropriate. They only send application forms and/or educational materials about expansion Medicaid to Medicare transitions.

Additionally, some states offer a buffer period during which the beneficiary has Medicare and is kept on some form of Medicaid while assessed for ABD Medicaid and an MSP. Typically, states provide this coverage to account for time-lags in identifying beneficiaries approaching Medicare eligibility and enrolling them into other programs.

### State highlight – New York

According to survey respondents from New York, the state uses a partial automation process. The state's Marketplace, New York State of Health (NYSoH), identifies individuals turning 65 through a data match with CMS and eMedNY (an electronic system used primarily to process Medicaid claims). These cases are transferred to the individual's local Medicaid office.

The Medicaid office sends out ABD Medicaid and MSP applications to individuals losing expansion Medicaid after receiving cases from NYSoH. The individual should also receive notices from their plan and NYSoH. Some individuals receive information about Part D, Extra Help, and Part B reimbursement.



### State highlight – Connecticut

According to survey respondents from Connecticut, the state uses a partial automation process. The state's Marketplace, Access Health CT, identifies individuals turning 65. These individuals receive notices within two months of their 65th birthday, including ABD Medicaid and MSP application materials. Individuals must complete and return materials within 20 days and send supporting documentation within 30 days to be assessed for programs by their Medicaid office. Individuals only interested in an MSP do not have to send supporting documentation.

Currently, CT is unable to detect when an individual becomes eligible for Medicare due to a disability.



### Termination notice only

States with termination-notice-only protocols only inform individuals when they are no longer eligible for expansion Medicaid (based on data matching for age and/or income). The state does not necessarily conduct eligibility determinations for other benefits, provide educational materials related to transitioning to Medicare, or send ABD or MSP applications along with termination notices.



## State highlight – West Virginia

According to survey respondents from West Virginia, the state uses a termination-notice-only process. The state's system identifies expansion Medicaid beneficiaries who are losing eligibility due to either a change in income or Medicare eligibility. These individuals receive closure letters explaining that they are losing their expansion Medicaid benefits. The state does not proactively conduct benefit screening.



Individuals interested in applying for ABD Medicaid and/or an MSP must contact their Medicaid office.

**Note:** According to advocate respondents, the reality of these transition processes does not always match up with the way they are described. Additionally, some states may fall into a fourth category and provide no termination notice, or termination notice after termination has already occurred.

## Troubleshooting

Beneficiaries may face a variety of problems when transitioning from expansion Medicaid to Medicare, and professionals may encounter these problems when helping their clients navigate coverage transitions. The following section reviews potential transition problems and steps that beneficiaries and advocates can take to avoid them.

### Identification problems

*Individual is not properly identified and so is not evaluated for ABD Medicaid or an MSP despite living in a state that uses an ex parte renewal process.*

Why this happens: State agencies may experience issues with data matching systems, preventing the state from identifying those who are eligible for Medicare. This problem leads to beneficiaries not being assessed for or enrolled in ABD Medicaid or an MSP. It is an especially common problem for Medicare-eligible individuals under 65.

What advocates can do: Contact the state Marketplace and/or the beneficiary's local Medicaid office. Ask directly about benefit redetermination and ensure that the beneficiary is being removed from expansion Medicaid due to Medicare eligibility. If this does not trigger an ex parte process, apply for benefits through the Medicaid office.

*Individual is not properly identified and so does not receive notification about expansion Medicaid ending due to Medicare eligibility.*

Why this happens: Often as a result of the previous issue, beneficiaries may receive no notice or educational information related to terminating expansion Medicaid benefits or Medicare enrollment.

What advocates can do: Explain that the individual is no longer eligible for expansion Medicaid due to Medicare eligibility, and ensure that they enroll in Medicare. Screen the individual for ABD Medicaid and MSP eligibility. If eligible, fill out and send applications to the local Medicaid office.

### Case study #1

Maria is under 65 and recently became eligible for Medicare. She lives in Connecticut and was recently told that her expansion Medicaid benefits would be terminating. She enrolled in Part B but is concerned about the cost of the Part B premium because of her low income. How should she proceed?

Tell Maria to call the Marketplace and explain that she was recently disenrolled from expansion Medicaid benefits due to Medicare eligibility. She should ask if she can be sent MSP and ABD Medicaid application materials. If Maria is only interested in an MSP, she should send back the verification notice with the box checked for MSP enrollment. She will not have to send supporting documentation. If she wants to apply for ABD Medicaid, she should complete the application and send required documentation.

She can also apply for benefits at her local Medicaid office.

### Determination problems

*Individual is incorrectly denied ABD Medicaid or MSP enrollment, or enrolled in the incorrect MSP.*

Why this happens: If a beneficiary was not contacted by the state, an ex parte renewal was likely attempted and the data used may have been outdated or not reflective of the individual's current income/asset levels. If the beneficiary was contacted for additional information, they may have thrown the mail away or received a complicated notice, leading to a miscommunication and incorrect assessment.

What advocates can do: In either case, contact the individual's local Medicaid office. The individual has the right to request a fair hearing to challenge the decision. Use updated information to show that the individual meets eligibility criteria. They also have the option of reapplying for benefits.



## Case study #2

Sarah has expansion Medicaid and lives in Rhode Island. She turned 65 and enrolled in Medicare, and received notices that her expansion Medicaid benefits are being terminated, and that she is ineligible for an MSP. However, Sarah's income level suggests that she should be eligible for QI. How should she proceed?

Sarah should receive a Notice of Action explaining that she was denied for an MSP and her right to request a fair hearing to challenge the decision. She should follow the instructions on the notice to request a fair hearing. She can also contact her local Medicaid office directly and try to reapply.

### Communication problems

*Individual turns down Part B, then learns that their expansion Medicaid benefits are ending.*

Why this happens: An individual with expansion Medicaid benefits may turn down Part B when they become Medicare-eligible because it comes with a monthly premium, or because they feel that they do not need additional insurance. This becomes an issue because Medicare eligibility means they cannot keep expansion Medicaid benefits—and so the individual could become completely uninsured. The individual likely was not informed in a timely manner that their expansion Medicaid benefits were being terminated. Many states do not provide Medicare enrollment education, so the individual may not have understood that they would need Medicare because they could not keep their expansion Medicaid benefits once Medicare-eligible.

Beneficiaries under 65 may experience this problem when given the option to take or turn down Part B after collecting SSDI for 24 months. Individuals age 65+ also face this issue when they are not automatically enrolled in Part B. Make sure to confirm that the individual is outside of their Initial Enrollment Period (IEP) before proceeding. An individual within their IEP can use it to enroll into Medicare without penalty.

What advocates can do: Screen the individual for MSP eligibility. Use an MSP to enroll them in Part B without penalty. If the individual is ineligible for an MSP, they should use the General Enrollment Period (GEP) to enroll in Part B. The GEP takes place January 1 through March 31 of each year, with coverage starting on July 1. Until that time, the individual will not be covered by Medicare. Enrolling during the GEP also means the individual may incur a Part B late enrollment penalty (LEP). Advocates should also screen the individual for Extra Help eligibility. Extra Help can eliminate any Part D LEP the individual may have incurred for delayed Part D enrollment.

### Case study #3

Chris is under 65 and lives in New York. He currently has expansion Medicaid and collects SSDI. He recently was offered the option to enroll in Part B, but he turned it down because he has his Medicaid benefits. However, he received termination notices from the Marketplace and his expansion Medicaid plan. He is now concerned that he will not have health insurance. How should he proceed?

Chris should see if he is eligible for ABD Medicaid and/or an MSP. He can contact his SHIP to be screened for eligibility if he is unsure. If eligible, he should contact his local Medicaid office for application materials. Enrolling in an MSP will enroll him into Part B and eliminate penalties.

If Chris is not eligible for these benefits, he should enroll in Part B during the GEP. He will face gaps in coverage and may incur a Part B LEP. Also remember to screen Chris for Extra Help—which could eliminate his Part D LEP— and provide Part D enrollment counseling.

## Conclusion

Many states have or are in the process of implementing promising practices to ensure a seamless transition from expansion Medicaid to Medicare for lower-income beneficiaries. However, there is still a great deal of room for improvement. States struggle with identifying transitioning individuals, making eligibility determinations (and processing subsequent enrollments), and communicating with individuals, both to provide timely notice of benefit termination and to provide educational information related to Medicare benefits.

As state advocates use this guide to educate themselves and assist their beneficiaries, they should also look to the work being done in other states to improve transitions. By continuing to identify state-specific problems (and successes) and learn about successful practices across the nation, it is hoped that we can think of new ways to engage with and improve expansion Medicaid transitions.