Program Overview and Policy
Chapter 1

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(Rev. 4, 08-21-20)

1.0 - Introduction

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Since the inception of the Medicare program in 1966, section 1843 of the Social Security Act ("the Act") has afforded states the option to enter into an agreement with the federal government under which the state commits to enrolling certain individuals dually eligible for Medicare and Medicaid (dually eligible individuals) in Medicare Part B with the state paying the Part B premiums on their behalf. Since January 1990, states could amend these agreements to pay the Part A premiums for certain dually eligible individuals who must pay a premium to enroll in Medicare Part A. Section 1903(a)(1) and (b) of the Act authorizes Federal Financial Participation (FFP) for the payment of Part A and/or Part B premiums and cost-sharing for certain dually eligible individuals.

The Centers for Medicare & Medicaid Services (CMS), through authority delegated by the Department of Health and Human Services (HHS), administers this process, historically referred to as "state buy-in."

This chapter sets forth consolidated policy guidance regarding the state buy-in program for the 50 states and the District of Columbia (DC). A forthcoming Chapter 7 will apply to the U.S. territories identified in 42 CFR §§ 407.42 and 407.43.

***NOTE:** This manual contains links to the Social Security Administration (SSA) Program Operations Manual System (POMS) as of July 2020.*[1]

1.1 - Definitions

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Buy-in Agreement ("agreement") means an agreement authorized by section 1843 of the Act, under which a state secures Premium-Part A or Part B coverage for "eligible individuals" (see definition below) in the buy-in group specified in the agreement, by enrolling them and paying the premiums on their behalf. See 42 CFR § 407.40.[2]

Buy-in Groups (also known as "coverage groups" in section 1843 of the Act) are identified by the state and are composed of multiple Medicaid eligibility categories

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1 The SSA POMS is the main reference for SSA employees to conduct daily business, including actions related to the state payment of Medicare premiums. As a courtesy to states, CMS provides links to the SSA POMS as of the time the manual was published. Changes may occur after release. To access the SSA POMS, go to https://secure.ssa.gov/apps10/poms.nsf/Home?readform.

2 Note that the Medicaid state plan (state plan) pre-print form includes pages that reflect the method the state uses to pay Medicare Part A and B premiums for dually eligible individuals. See state plan, section 3.2(a).

specified in the agreement.[3] *See 42 CFR §§ 406.26 and 407.42.*

Eligible Individual (Part B) means an individual who is entitled to Medicare Part A or who is age 65 or over, is a resident of the United States and is either a U.S. citizen, or an alien lawfully admitted for permanent residence who has resided in the U.S. continuously during the five years immediately preceding the month the individual applies for enrollment under Part B, and has not been convicted of crimes specified in 42 CFR § 407.10(b). See section 1836 of the Act; 42 CFR § 407.10.

Entitled to Medicare Part A refers to individuals who receive Part A, either without payment of a premium (Premium-free Part A) or by paying a premium (Premium-Part A). Such individuals satisfy both the eligibility requirements set forth in 42 CFR § 406.5 and the application or enrollment conditions set forth in 42 CFR § 406.6. See 42 CFR § 406(a).

General Enrollment Period (GEP) for Part B means the annual period (January through March, with coverage effective July 1) for an individual to apply for Part B if the individual did not apply during their Initial Enrollment Period (IEP). See 42 CFR § 407.15.

General Enrollment Period (GEP) for Premium-Part A means the annual period (January through March, with coverage effective July 1) for an individual to apply for Premium-Part A if the individual did not apply during their IEP. See 42 CFR § 406.21(c).

Group Payer Arrangement means an alternative method that may be used to pay Part A or Part B premiums on behalf of certain beneficiaries. See 42 CFR §§ 406.32(g) and 408.80.

Initial Enrollment Period (IEP) means the seven-month period comprising the three months before an individual meets the requirements for Premium-Part A or becomes eligible for Part B, the month the individual meets the requirements for Premium-Part A or becomes eligible for Part B, and the three months following. See 42 CFR §§ 406.21(b) and 407.14.

Member of a Buy-in Group means an individual who is a member of the buy-in group that the state has elected to include in its agreement under section 1843 of the Act. States may only cover an eligible individual who is a member of the buy-in group under the agreement. See 42 CFR §§ 407.40, 407.42, and 407.43.

Premium Increase for Late Enrollment (also known as "Premium Surcharge") means the additional amount that may be charged to an individual who enrolls in Premium-Part A or Part B after expiration of the individual's IEP or who reenrolls after previous

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3 Generally, Medicaid beneficiaries are classified based on the eligibility "group" under which each beneficiary qualifies. For purposes of this Manual, we use the term "category" instead of "group" in order to avoid confusion with the reference to "buy-in group" in 42 CFR § 407.40 et. seq.

coverage. For Part B, the premium is increased ten percent for each cumulative period of 12 full months during which an individual could have been, but was not enrolled in Part B. See 42 CFR § 408.22. For Premium-Part A, effective for premiums due for July 1986 and after, the premium increase is limited to ten percent and is payable for twice the number of full 12-month periods determined under the regulations. See 42 CFR § 406.32(d).

Premium-Part A means the hospital insurance benefits provided under Medicare Part A for certain individuals who do not qualify for Part A without monthly premiums under 42 CFR § 406.5(a) and can only enroll in Part A by paying a premium. See 42 CFR §§ 406.5(b) and 406.20.

1.2 - Background

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Medicare provides health insurance coverage to individuals age 65 and older and certain persons under age 65 with disabilities or End-Stage Renal Disease (ESRD). Medicare Part A provides coverage generally of inpatient care, and most beneficiaries are entitled to these benefits without paying an additional premium based on eligibility for Social Security or Railroad Retirement Board (RRB) benefits. Some individuals are eligible to obtain entitlement to Part A benefits by enrolling in Premium-Part A. Medicare Part B, which is optional and requires payment of a premium, covers most other types of health coverage, including limited prescription drug coverage. Medicare Part D, also optional, requires a premium, and covers outpatient prescription drugs. Medicare Parts A, B, and D all require payment of cost-sharing (e.g., deductibles, coinsurance, and copayments).

Under the state buy-in program, states, the District of Columbia (DC), and specified U.S. territories can enter into buy-in agreements that make it easier to enroll certain Medicaid recipients into Medicare Part B and pay the premiums on their behalf ("Part B buy-in"). See section 1843 of the Act; 42 CFR § 407.40, et seq. All states, DC, and some of the specified U.S. territories have elected to enter into a Part B buy-in agreement with CMS.

Starting January 1, 1990, states could expand their buy-in agreements to enroll Qualified Medicare Beneficiaries (QMBs) in Premium-Part A and pay the premiums on their behalf ("Part A buy-in"). See section 1818(g) of the Act; 42 CFR § 406.26. Most states and DC have broadened their buy-in agreements to include the payment of Part A premiums for individuals eligible for the QMB program. The remaining states use the group payer arrangement to pay Part A premiums for QMBs. See section 1.7 for more information about paying Part A premiums for QMBs and appendix 1.D for a list of Part A buy-in and group payer states.

For an individual who is determined eligible for but not yet enrolled in Medicare, state buy-in serves to enroll the individual in Medicare Part A and/or B and directs the federal government to bill the state for his or her premiums. For an individual who is already enrolled in Medicare, state buy-in means the federal government will start billing the state for the individual's Medicare premiums and stop billing the individual for these

costs through deductions from their monthly Social Security benefits (Old Age, Survivors, and Disability Insurance (OASDI) program)[4] or through bills CMS directly mails certain beneficiaries.[5]

Low-income individuals who receive assistance with Medicare premiums save critical funds to use for other life necessities, including food and housing. A beneficiary's monthly expenses will drop by the amount of their Part B premium ($144.60 in 2020) once buy-in starts.[6] Eligible individuals without Medicare can enroll in the program and access Medicare services.

Buy-in agreements simplify the process for states to assist their low-income residents with Medicare expenses. Buy-in agreements permit states to directly enroll eligible individuals in Medicare Part A and/or B at any time of the year (without regard for Medicare enrollment periods) and to pay beneficiary premiums. CMS does not bill states with buy-in agreements for late enrollment or re-enrollment charges that may otherwise apply to an individual's monthly premium amount.

Easing the administrative processes for a state to pay Medicare premiums helps maximize the number of its "full-benefit" Medicaid recipients who are enrolled in Medicare, ensuring that Medicare pays primary to Medicaid. State buy-in agreements also facilitate enrollment in Medicare for low-income individuals not eligible for full-benefit Medicaid coverage[7] by paying Medicare premium and cost-sharing costs through three Medicare Savings Program groups: QMB, Specified Low-Income Medicare Beneficiaries (SLMB), and Qualifying Individuals (QI). The state's regular Federal Medical Assistance Percentage (FMAP) rate applies to state expenditures for Medicare Parts A and B premiums and cost-sharing for certain Medicaid eligibility categories (see section 1.9).

1.3 - Medicare Eligibility and Enrollment

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CMS regulations require states to enroll members of a buy-in group in buy-in if they meet

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4 OASDI benefits include Old Age Insurance Benefit Payments (also known as Social Security retirement benefits) and Social Security Disability Insurance (SSDI).

5 CMS sends the beneficiary a Medicare Premium Bill (CMS-500) (see https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS500.pdf) for Medicare Parts A, B, and/or D if the beneficiary's premium liability exceeds the amount of the beneficiary's Social Security benefit or Office of Personnel Management (OPM) or Railroad Retirement Board (RRB) annuity.

5 Most beneficiaries pay the standard Part B premium amount ($144.60 in 2020). States also pay the standard Part B premium amount on behalf of individuals enrolled in buy-in. See SSA POMS HI 01001.004 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0601001004.

7 "Full-benefit" Medicaid coverage generally refers to coverage for a range of items and services, beyond Medicare premiums and cost-sharing, that individuals may receive by qualifying for a mandatory Medicaid eligibility category (see 42 CFR § 435(b)), an optional Medicaid eligibility category (see 42 CFR § 435(c)) or a medically needy category (see 42 CFR § 435(d)) as provided for in the state plan.

the requirements for Medicare Parts A and/or B (an "eligible individual" as defined in section 1.1). See 42 CFR § 407.40(c).
This section summarizes Medicare eligibility requirements and enrollment processes to help states understand which Medicaid recipients may qualify for Medicare and become dually eligible.

1.3.1 - Premium-free Part A

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Certain individuals qualify for Premium-free Part A if they have the number of Social Security work credits required to qualify for monthly OASDI benefits.[8] Most Medicare beneficiaries get Premium-free Part A.

An individual age 65 or over meets the requirements for Premium-free Part A if the individual:

- *Already gets Old Age Insurance Benefit Payments (Social Security retirement benefits) or an Age and Service Annuity from the RRB (RRB retirement benefits) ;*
- *Is eligible to get Social Security or RRB retirement benefits but has not filed for them yet; or*
- *Is a government employee who paid the Medicare payroll tax while working for the required amount of time.*

An individual under age 65 meets the requirements for Premium-free Part A if the individual:

- *Has received Social Security Disability Insurance (SSDI) or a disability annuity from RRB (RRB disability benefits) for 24 months; or*
- *Has ESRD and the requisite work credits to otherwise qualify for Social Security or RRB disability benefits (or is a spouse or dependent child[9] of an individual who does).*

All individuals who qualify for Medicare on the basis of ESRD and the vast majority of individuals who qualify for Medicare on the basis of SSDI benefits receive Premium-free Part A.

***NOTE:** An individual who has ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), qualifies for Premium-free Part A the month the individual's SSDI benefits begin.*

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8 An individual accrues Social Security work credits when the individual pays Medicare payroll taxes while working (or is a spouse or dependent child of an individual who does). See 20 CFR § 404(b).
9 For information about qualifying for ESRD Medicare as a dependent child, see SSA POMS DI 45001.001 at https://secure.ssa.gov/poms.nsf/lnx/0445001001.

1.3.2 - Premium-Part A

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Individuals who lack the requisite Social Security work credits to qualify for OASDI can obtain Premium-Part A. See 42 CFR § 406.5(b).

Individuals age 65 or older qualify for Premium-Part A if they are:

- *U.S. residents;*
- *Receiving benefits under Part B or are in the process of enrolling in it;*
- *Not otherwise entitled to Part A; and*
- *Either:*
  - *U.S. citizens; or*
  - *Lawful permanent residents who have resided in the U.S. continuously during the five years immediately preceding the month they applied for enrollment in Medicare.[10] (See section 1818 of the Act; 42 CFR § 406.20(b)).*

In addition, individuals under age 65 qualify for Premium-Part A if they:

- *Were entitled to Premium-free Part A on the basis of entitlement to SSDI;*
- *Have lost entitlement to Premium-free Part A due to excess earnings;*
- *Are not otherwise entitled to Part A; and*
- *Continue to have a qualifying disability. (See section 1818(a) of the Act; 42 CFR § 406.20(c)).*

***NOTE:** As described in section 1.3.1, the vast majority of individuals under age 65 with disabilities qualify for Premium-free Part A. Individuals under age 65 only qualify for Part A with a premium if they: (1) lose disability benefits and Premium-free Part A after returning to work, and (2) continue to have a qualifying disability. States pay the Part A premiums for such individuals under age 65 who meet the requirements of the Qualified Working and Disabled Individuals (QDWI) program.[11] For more information about the QDWI program, see section 1.6.2.*

Individuals may qualify to pay a reduced monthly Part A premium under certain circumstances.[12] See 42 CFR § 406.32(c).

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10 The five years of continuous residence may begin prior to the date that the lawful admission for permanent resident is granted. See SSA POMS HI 00805.005 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600805005 and SSA POMS GN 00303.800 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0200303800.

11 The QMB program is not available to individuals entitled to Part A solely based on eligibility to enroll as a QDWI. Section 1905(p)(1)(A) of the Act; 42 CFR §400.200. For more information about the QMB program, see section 1.6.2.1.

12 Individuals may qualify for a reduced premium if they have obtained 30 work credits; were married for at least one year to a worker with at least 30 work credits; married for at least one year to a worker who

1.3.3 - Medicare Part B

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

All individuals eligible for Part B are charged a monthly premium through a deduction from their OASDI, RRB, or Office of Personnel Management (OPM) government retirement benefits; or a bill is mailed directly by CMS.[13]

Individuals who are entitled to Part A are also eligible to enroll in Medicare Part B. See section 1836(1) of the Act.

Individuals who are not entitled to Part A can enroll in Medicare Part B if they are age 65 or older and meet the citizenship and residency requirements for Premium-Part A. See 42 CFR § 407.10(a)(2). In other words, they must be:

- *Age 65 or older*
- *U.S. residents; and*
- *Either:*
  - *U.S. citizens; or*
  - *Lawful permanent residents who have resided in the U.S. continuously during the five years immediately preceding the month of application for enrollment in Medicare.*[14]

1.3.4 - Medicare Enrollment

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

In the absence of a buy-in agreement, individuals may only sign up for Premium-Part A or Part B during a prescribed Medicare Enrollment Period. Individuals can first sign up for Premium-Part A or Part B during the IEP. If they miss the IEP, they can only enroll during the annual GEP and may pay a premium increase for late enrollment.[15] *For an*

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attained 30 work credits prior to their death; divorced from a worker after 10 years of marriage and the worker attained 30 work credits at the time the divorce was final; divorced from a worker after 10 years of marriage and the worker died and had 30 work credits at the time the divorce was final, or the current spouse has at least 30 Social Security work credits. See 42 CFR § 406.32(c).

13 Note that Medicare Advantage plans can reduce the standard Medicare Part B premium as an additional benefit for plan enrollees. The reduction must be less than the standard Part B premium amount and cannot be paid to the beneficiary or used to reduce a premium surcharge. If an individual receives a Part B premium deduction from a Medicare Advantage plan and is enrolled in Part B buy-in, CMS will notify the state of the amount of the premium reduction (not the adjusted premium rate) through the regular exchange of buy-in data.

14 The five years of continuous residence may begin prior to the date that the lawful admission for permanent resident is granted. See SSA POMS HI 00805.005 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600805005 and SSA POMS GN 00303.800 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0200303800.

15 An individual who declined Part B during their IEP and is or was covered by an employer group health plan, may qualify for a time-limited Special Enrollment Period (SEP) to enroll in Part B without any

explanation of the premium increase for Premium-Part A, see section 1.1. Medicare enrollment periods do not apply to Premium-free Part A. Some individuals are automatically enrolled in Medicare, while others have to file for it, as described in section 1.3.4.1.

1.3.4.1 - Medicare Enrollment Table

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Automatic Enrollment	***Individual Enrollment[16]***
Individuals automatically get Premium-free Part A if they are: ***Age 65 and over and receive Social Security or RRB retirement benefits; or*** ***Under age 65 who receive Social Security or RRB disability benefits for 24 months.*** --- ***During their IEP for Part B, CMS mails the individual a welcome packet that contains background information and a Medicare card with the Part A and B effective dates. The mailing informs the beneficiary that:*** ***They do not pay a premium for Part A, which will start on the coverage date on the card; and*** ***They do owe a premium for Part B, but can decline it by signing the back of the card and returning the card before the Part B effective date.***	***Premium-free Part A:*** *Individuals can file for Medicare Premium-free Part A at SSA if they are:* *Age 65 and over and have not yet filed for Social Security or RRB benefits;* *An individual who qualifies for Medicare on the basis of ESRD; or* *A government employee who has paid the Medicare payroll tax for the required number of quarters.* *Individuals who file for Part A are enrolled in Part B unless they decline it.* ***Premium-Part A:*** *Individuals who qualify for Premium-Part A must apply for Medicare at SSA. They can enroll in Part B only or Premium-Part A and Part B.* ***NOTE****: An individual can enroll in Medicare Part B without enrolling in Premium-Part A. Conversely, an individual cannot enroll in Premium-Part A unless the individual is receiving Part B benefits or files an application to enroll.* ***Part B:*** *Individuals who did not enroll in Part B during their IEP for Part B can enroll in Part B during the GEP or during a Special Enrollment*

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applicable premium increases for late enrollment. For more information, see 42 CFR § 407.20; SSA POMS HI 00805.275 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600805275.

16 An individual can sign up for Medicare through SSA's toll-free number 1-800-772-1213, TTY 1-800-325-0778, by making an appointment at their local Social Security office, and with some exceptions, on the ssa.gov website.

Automatic Enrollment	Individual Enrollment[16]
	Period (SEP) for those with current or former group employer coverage.

1.3.5 - Medicare Re-enrollment

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

An eligible individual who owes premiums from a past period of Premium-Part A or Part B coverage is permitted to re-enroll in Medicare. Payment of past-due premiums is not a pre-requisite for re-enrollment. See SSA POMS HI 01001.345 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0601001345.

1.4 - Requirements for Enrolling Individuals Under Buy-in Agreements

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

All states have a buy-in agreement for Part B buy-in, and most have an agreement for Part A buy-in. The agreements and related Medicaid state plan (state plan) pages identify the buy-in groups for which the state will cover Part A or B premiums. See sections 1.6 and 1.7 for information about state buy-in group options.

States must pay the Part A or B premiums for any eligible individual who is a member of the buy-in group. See sections 1843(a) and 1818(g) of the Act; 42 CFR § 407.40(c)(1). A state cannot apply a "cost-effectiveness test" to choose individuals for buy-in (i.e., restrict buy-in to those who incur medical expenses).

Under buy-in agreements, states initiate buy-in for eligible individuals who are members of the buy-in group at any time of the year, without any premium surcharges. If a member of a buy-in group is already enrolled in either Medicare Part A or B, the state should directly enroll the individual in buy-in and refrain from referring the individual to SSA to apply for Medicare. See section 1.10 for more information.

States must follow federal requirements defining an individual's buy-in coverage period, including effective (start) and termination (stop) dates. See 42 CFR §§ 406.26, 407.47, and 407.48, and sections 1.13 through 1.15. States must honor the applicable buy-in start and stop dates, even if buy-in processing is delayed. See chapter 2 for information regarding state and CMS processes to start and end buy-in.

NOTE: If SSA makes a retroactive award of SSDI benefits, and the disability entitlement date is more than 24 months in the past, SSA will retroactively establish Part A entitlement (starting the 25th month after the SSDI entitlement date). If a state learns that SSA established retroactive Medicare Part A entitlement for an individual, the state must review the individual's eligibility for Part B buy-in over the retroactive period.

An individual's enrollment under a buy-in agreement is involuntary. States must enroll

an individual in buy-in if the individual applies for Medicaid and is determined eligible for a Medicaid eligibility category included in the state's buy-in coverage group.[17] A beneficiary cannot voluntarily terminate state buy-in coverage. See sections 1843(a) and 1818(g) of the Act; 42 CFR § 407.40(c)(1).

Eligibility for or enrollment in Medicare constitutes "a change in circumstances" that may affect an individual's Medicaid eligibility.[18] When a state anticipates or receives information that a current Medicaid recipient is newly eligible for Medicare, the state must promptly redetermine the individual's eligibility as required any time a beneficiary experiences a change in circumstances that may impact eligibility. See 42 CFR § 435.916(d). If the state finds the Medicaid beneficiary is no longer eligible for the eligibility category under which the individual is receiving coverage, the state must consider whether the beneficiary may be eligible under another eligibility category covered by the state. See 42 CFR § 435.916(f)(1). The state must continue to furnish Medicaid until an individual is determined ineligible. See 42 CFR § 435.930(b).

When the state has considered eligibility on all bases, the state must either move the beneficiary to the appropriate category if Medicaid eligibility continues, or provide the individual advance notice and hearing rights in accordance with 42 CFR Part 435, Subpart J and 42 CFR Part 431, Subpart E prior to terminating coverage. If the state determines the individual eligible for a Medicaid category included in the state's buy-in group, the state must start paying the Part A and/or B premiums for this individual.

***NOTE:** When an individual enrolled in Medicaid under 42 CFR § 435.119 (also known as the "adult group" or "adult category") becomes eligible for Medicare, the individual no longer meets the eligibility criteria for the adult category. The state must promptly redetermine eligibility based on the change in circumstances. The beneficiary must remain covered under the adult category until the state completes the redetermination of eligibility on all bases. In such instances, if the state includes all Medicaid beneficiaries in its Part B buy-in coverage group, the state will need to pay the beneficiary's Part B premiums for the months in which the beneficiary was enrolled in the adult category.*

Similarly, if an individual enrolled in a Medicaid category included in the state's buy-in group, experiences a change in circumstance and is determined to no longer meet the eligibility criteria for that category, the state must promptly redetermine eligibility in order to determine if the individual may be eligible under a different Medicaid category, including those encompassed by the buy-in group. See 42 CFR § 435.916(f). While the state is making this determination, the state must maintain Medicaid coverage and must not terminate the individual from buy-in. See 42 CFR § 435.930(b). Further, if the state determines the individual continues to qualify under another buy-in group category, buy-

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17 In states with 1634 agreements, an SSI application also serves as a Medicaid application. For more information about 1634 agreements, see section 1.6.1.1.

18 For more information, see "Strategies to Streamline Transitions for Medicaid-eligible Beneficiaries Who Newly Qualify for Medicare," CMS Information Bulletin, June 7, 2017 at https://www.medicaid.gov/federal-policy-guidance/downloads/cib060717.pdf.

in coverage must continue without interruption.

Medicaid agencies communicate all enrollment and disenrollment information through the established data exchange process with CMS. CMS' Third Party System (TPS) will process all state-submitted buy-in actions. Buy-in data identifies each Medicaid recipient who is enrolled in Medicare, and for whom the state is paying the Part A or B premium. See chapter 2 for information about state-CMS buy-in data exchange.

1.5 - Effect of Buy-in on an Individual

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

If an individual is eligible for Medicare but not currently enrolled in it, *state buy-in enrolls the individual in Medicare, providing access to Medicare-covered items and services.*

NOTE: *If an individual did not enroll in Premium-Part A or Part B during their IEP, or previously withdrew from the programs, Medicare entitlement will be established or re-established effective with the first month that the individual becomes eligible for state buy-in.*

If an individual is already enrolled in Medicare, *state buy-in means the state will assume payments for the beneficiary's Medicare Part A or B premiums.*

- *If SSA deducts Medicare premiums from a beneficiary's Social Security benefit (OASDI or Supplemental Security Income (SSI)), OPM or RRB benefits, the deductions will stop, resulting in the beneficiary receiving a higher monthly payment.*
- *If CMS directly bills the beneficiary for Medicare Part A and/or Medicare Part B, such billing will end.*

Once buy-in coverage is effective, the beneficiary shall receive a refund from SSA for any premiums (including any late enrollment penalties) that were deducted from the benefit amount or for premiums directly paid by the beneficiary to CMS, for any month the beneficiary is enrolled in state buy-in. Sometimes, a state accretes a beneficiary to the state's buy-in account in error, for months in which the individual was not eligible. States must provide buy-in coverage as if the beneficiary was in fact eligible and only end coverage as provided in 42 CFR § 407.48. In these instances, the beneficiary is entitled to keep any premium refunds received. The state must treat the individual as if they are eligible and may not attempt to recoup these amounts from the beneficiary.[19]

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19 Recovery of an "overpayment" made to beneficiaries is considered to be a retroactive termination of Medicaid eligibility. Retroactive termination of eligibility is prohibited by regulations at 42 CFR §§ 431.211 to 431.214, which require states to provide at least ten days advance notice of a termination of eligibility in most situations; in a few discrete situations, termination on the date of action is allowed. Retroactive terminations of eligibility would also violate a beneficiary's due process rights under the U.S. Constitution and associated case law.

NOTE: *The refund of Medicare premiums is not countable income under SSI methodologies. As a result, Medicaid agencies cannot consider the refund as income when determining eligibility for individuals whose Medicaid eligibility is based on SSI methodologies.*

1.6 - Part B Buy-in Coverage Groups - General

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Federal law allows states to select one of three Part B buy-in coverage groups. See section 1843 of the Act; 42 CFR §§ 407.42 and 407.43.[20] The buy-in groups are listed below, in order of narrowest to broadest.

- *Cash Assistance Recipients and Deemed Recipients of Cash Assistance (Section 1.6.1)*
- *Cash Assistance Recipients and Deemed Recipients of Cash Assistance Plus Three Medicare Savings Program (MSP) Groups (Section 1.6.2); and*
- *All Medicaid Categories (Section 1.6.3)*

As of July 2020, all states, DC, and certain territories have Part B buy-in agreements that include either (a) the cash assistance recipients and deemed recipients of cash assistance plus three MSP groups or (b) all Medicaid Categories.[21]

NOTE: *Part B buy-in coverage groups must include SSI/State Supplement Programs*

States are required to provide Medicaid to eligible state residents under 42 CFR § 435.403(a)) and must continue to furnish Medicaid to all eligible individuals until they are found to be ineligible pursuant to 42 CFR § 435.930(b). When a state receives information that suggests a beneficiary is not eligible for Medicaid, the state must promptly conduct a redetermination of eligibility for this beneficiary. See 42 CFR § 435.916(d)(1). This includes providing the beneficiary with an opportunity to demonstrate that the information the state received is not accurate or that the individual otherwise remains eligible for coverage. See 42 CFR § 435.952(d). If the redetermination results in a finding of ineligibility for the beneficiary, the state may terminate eligibility provided that the beneficiary is afforded advance notice and hearing rights in accordance with 42 CFR Part 435, Subpart J and 42 CFR Part 431, Subpart E.

20 When states could first enter into buy-in agreements in July 1966, they could choose between two Part B buy-in groups: 1) individuals receiving federally-aided cash assistance; or 2) all Medicaid recipients. After numerous changes, federal law allows states to select one of the three buy-in groups outlined in this section.

21 CMS has deemed all buy-in agreements to include Part B buy-in for QMBs, SLMBs, and QIs. CMS (then the Health Care Financing Administration (HCFA)) deemed all agreements to include Part B buy-in for QMBs starting January 1, 1989. See 56 Fed. Reg. 38074 at 38076 (August 12, 1991). Starting January 1, 1993, SLMB's effective date, all agreements were deemed to include SLMBs because the Act treats SLMBs like QMBs. See section 1843(h)(3) of the Act. Long-standing CMS operations effectively deem the agreements to include Part B buy-in for QIs, enacted in 1997. The state plan pre-print (3.2 Coordination of Medicaid with Medicare and Other Insurance) treats QIs the same as SLMBs.

(SSPs) recipients and deemed recipients of SSI/SSPs who qualify for Medicaid based on receipt (or deemed receipt) of such cash assistance. Aid to Families with Dependent Children (AFDC) is a cash assistance program that was replaced by Temporary Assistance for Needy Families (TANF), in 1996.[22] No Medicaid state plan eligibility groups are linked to TANF; a few Medicaid eligibility categories, however, are linked to eligibility standards of the former AFDC program and offer eligibility to certain individuals who meet such standards, as the program existed in 1996. Consistent with long-standing policy, states can choose to include one of these AFDC-related groups, Children with Adoption Assistance, Foster Care, or Guardianship Care under Title IV-E ("Children Eligible Based on Title IV-E") in their Part B buy-in coverage group as explained below.

1.6.1 - Cash Assistance and Deemed Recipients of Cash Assistance

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

This buy-in group includes only cash assistance and deemed recipients of cash assistance who are covered under the state plan as categorically needy.[23]

1.6.1.1 - Supplemental Security Income (SSI) Program

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

SSI is a federal cash assistance program that serves low-income individuals who are age 65 or older, or have blindness or a disability. In most states, the receipt of SSI is a mandatory basis for Medicaid eligibility. Pursuant to section 1634(a) of the Act, "1634" states have an agreement with SSA to determine Medicaid eligibility for state residents whom SSA has determined eligible for SSI. 1634 states are also known as "auto-accrete" states because CMS will initiate, on behalf of the state, Part B buy-in for individuals receiving SSI.

Other states are referred to as "alert" states. In alert states, CMS identifies for states SSI recipients who are Medicare-eligible, but the states, not SSA, determine Medicaid eligibility and initiate Part B buy-in enrollment. Alert states fall into two categories: SSI criterion states and "209(b)" states.

Like 1634 states, SSI criterion states apply SSI methodologies in determining Medicaid eligibility. Unlike 1634 states, SSI criterion states require SSI beneficiaries to complete a Medicaid application for the state to establish their Medicaid eligibility. 209(b) states have elected the option, under section 1902(f) of the Act, to apply financial methodologies more restrictive than SSI in determining Medicaid eligibility for individuals age 65 or older, or have blindness or disability.[1] In 209(b) states, the receipt

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22 The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. 104-193).
23 SSA notifies Medicaid agencies of individuals who are determined eligible for SSI (and SSPs, in some cases) and may qualify for Medicare through the SSA systems such as the State Data Exchange (SDX). See chapter 2, section 2.4 for more information about SSA data sharing with states.

of SSI is not a basis for Medicaid eligibility. However, 209(b) states must have a mandatory Medicaid eligibility group that serves low-income individuals who are age 65 or older, or have blindness or a disability under 42 CFR § 435.121; many, if not most, SSI beneficiaries in 209(b) states qualify in this category. See chapter 2, section 2.5.1 for information about buy-in enrollment processes in auto-accrete and alert states.

Appendix 1.D classifies states by whether they are an auto-accrete or alert state (including SSI criterion and 209(b)) as of July 2020.

1.6.1.2 - State Supplement Programs (SSPs)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Most states operate their own cash assistance programs—known as optional SSPs—for people who are 65 years old and older, or who have blindness or disability. Payments from these programs are not counted as income under the SSI program. In many cases, these benefits supplement the SSI benefits an individual receives.[24] In other cases, individuals receive only an SSP payment if they would otherwise meet the requirements for SSI but for having too much income. States have the option to extend categorical eligibility to individuals who are not eligible for SSI, but who receive an SSP benefit.

Under the authority of section 1616 of the Act, many states have entered into "1616 agreements" with SSA to determine eligibility for their SSPs and to issue SSP payments to beneficiaries. In such states, an application for SSI is an application for SSPs. Other states perform determinations for SSPs themselves. See SSA POMS SI 01401.001 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0501401001.

1.6.1.3 - Deemed Recipients of Cash Assistance
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Over time, federal law has mandated that certain individuals who were at one point receiving cash assistance but who lost it due to increases in Social Security benefits (OASDI) be treated, for purposes of Medicaid eligibility, as if they continue to receive cash assistance, i.e., these individuals are "deemed" to be receiving SSI/SSPs. Federal law and regulations make these individuals mandatorily eligible for Medicaid.[25] These

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24 States in which the grant-in-aid cash benefit rate in December 1973 exceeded the SSI Federal Benefit Rate of January 1974, are required to pay a supplement to beneficiaries to make up the difference. Individuals who continue to receive these mandatory state supplements are mandatorily eligible for Medicaid. See 42 CFR § 435.130. There are no new applicants for this eligibility group.

25 The following categories are deemed recipients of SSI/SSPs: certain individuals who would have been eligible for cash assistance in 1972 but who lost it because of an increase in their OASDI benefits (42 CFR § 435.134); certain individuals (sometimes known as "Pickle" individuals) who used to qualify for both SSDI and SSI but who no longer qualify for SSI because their income exceeds the SSI income limit (42 CFR § 435.135); certain disabled widow/ers (42 CFR §§ 435.137 and 435.138); and certain adult children with disabilities (section 1634(c) of the Act).

individuals must be included in state buy-in agreements.

1.6.1.4 - Children Eligible Based on Title IV-E
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

At state option, Part B coverage groups may include children (who may be up to age 21) enrolled in the state plan categorical eligibility group, Children Eligible Based on Title IV-E, under 42 CFR § 435.145.[26] Title IV-E of the Act provides for federal payments to states for foster care and kinship guardianship care maintenance and for adoption assistance on behalf of children who meet the program's eligibility requirements. Based on the Title IV-E agency's determination of eligibility, the Medicaid agency must provide Medicaid to the Title IV-E individual.

Consistent with the requirements described at 42 CFR § 435.145, the eligibility criteria for the title IV-E eligibility group require that, for a child, either: (1) an adoption assistance agreement with a state or tribe is in effect under title IV-E of the Act; or (2) the state or tribe is making foster care or kinship guardianship assistance maintenance payments under title IV-E of the Act.

Individuals meeting the eligibility requirements are "automatically" eligible for the title IV-E eligibility group and are typically enrolled without a Medicaid application.

1.6.2 - Cash Assistance Recipients and Deemed Recipients of Cash Assistance Plus Three Medicare Savings Program (MSP) Groups
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Pursuant to section 1902(a)(10)(E) of the Act, states must assist low-income Medicare beneficiaries with their Parts A and B expenses through one of four "Medicare Savings Programs," or "MSPs."

- *QMBs*
- *SLMBs*
- *QIs*
- *QDWI*

Under this buy-in coverage group, states cover QMBs, SLMBs, and QIs in addition to the cash assistance-related and deemed cash assistance-related coverage categories

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[25] Medicaid eligibility categories linked to AFDC, as in effect in 1996, include Children with Adoption Assistance, Foster Care, or Guardianship Care under Title IV-E. See sections 473(b)(1), 473(b)(3) and 1902(a)(10)(A)(i)(I) of the Act. Another category that treats individuals as though they were receiving AFDC is the Low-Income Families category consisting primarily of parents and other caretaker relatives and their dependent children living in the home. See section 1931 of the Act. Consistent with longstanding policy, individuals eligible in this latter category are not optional deemed recipients of AFDC for buy-in. Note that parents and other caretaker relatives in this category (who are most likely to qualify for Medicare) will, in the vast majority of cases, be eligible for a MSP group.

described in section 1.6.1.

***NOTE:** States pay Part A premiums (but not Part B premiums) for QDWIs. QDWIs are individuals under age 65 who became entitled to Part A based on their receipt of SSDI, but who subsequently lost SSDI, and, as a result, their Part A entitlement, on the basis of substantial gainful employment.[27] States cannot include the Part A premium payments for QDWIs in their buy-in agreements. States pay the Part A premiums for QDWIs through the group payer process.*

Individuals apply for Medicaid and/or the MSPs through their state Medicaid agencies. Additionally, federal law requires the Social Security Administration (SSA) to transmit to states "leads" data from Medicare Part D Low-Income Subsidy (LIS) applications processed by SSA (i.e., files containing data from LIS applications), and for states to treat the data as an application for the MSPs. See sections 1144(c)(3) and 1935(a)(4) of the Act. For more information about LIS leads data, see chapter 2, section 2.4.2.5.

State Medicaid agencies are generally required to determine an individual's eligibility for all categories for which they may qualify, including full-benefit Medicaid categories and MSPs. Accordingly, the eligibility system hierarchy should be programmed to reflect both determinations. Note that some states may have MSP-only applications that do not request the information necessary for categorical Medicaid determinations. Consistent with regulations governing eligibility determinations, states must explore all bases of eligibility. See 42 CFR § 435.911(c).

States must use income and resource methodologies and requirements no more restrictive than SSI's for MSP determinations. See 42 CFR § 435.601(b)(2). Under section 1902(r)(2) of the Act, states have the flexibility to expand eligibility by employing less restrictive rules in counting income and resources and using a more expansive definition of family size for MSP determinations. See 42 CFR § 435.601(d)(1).[28]

As noted in section 1.6, QMBs, SLMBs, and QIs are included in all state buy-in agreements in the 50 states and Washington D.C.

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27 QDWIs have income up to 200 percent of the FPL, resources that do not exceed two times the SSI resource standard, and are not otherwise eligible for Medicaid. Note: Low-income individuals under age 65 with disabilities who have lost SSDI due to excess earnings may qualify for full-benefit Medicaid coverage (e.g., the Work Incentives Eligibility Group under section 1902(a)(10)(A)(ii)(XIII) of the Act).

28 For example, states can disregard specific amounts of income or amounts or categories of assets, or effectively remove the asset limit by disregarding all assets. For more information on state flexibilities, see "Enrollment and Retention Flexibilities to Better Serve Medicare-Eligible Medicaid Enrollees" CMS Information Bulletin, January 23, 2015 at https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/CIB-01-23-2015.pdf. See also, "Improving Participation in the Medicare Savings Programs," Chapter 3 in June 2020 Report to Congress on Medicaid and CHIP, Medicaid and CHIP Payment and Access Commission (MACPAC) at https://www.macpac.gov/publication/chapter-3-improving-participation-in-the-medicare-savings-programs/.

Current income and asset limits for the MSP categories are available at https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html.

The sub-sections below contain additional information about the QMB, SLMB, and QI groups.

For detailed information on dually eligible individual categories, including the degree to which individuals in each category receive assistance with Medicare Parts A and B premiums and cost-sharing, see appendix 1.A.

For more information about the buy-in start date for these categories, see sections 1.13 and 1.14, and appendix 1.C.

1.6.2.1 - Qualified Medicare Beneficiary (QMB) Program

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Under the QMB eligibility category, states pay the Medicare Parts A and B cost-sharing expenses (i.e., monthly premiums, deductibles, coinsurance, co-payments,[29] and at state option, Part C premiums) for individuals who:

- *Are entitled to Medicare Part A (including individuals age 65 and over who are entitled to Premium-Part A);[30]*
- *Have income that does not exceed 100 percent of the federal poverty level (FPL); and*
- *Have resources that do not exceed the full LIS resource standard of three times the SSI resource limit, adjusted annually in accordance with increases in the Consumer Price Index (CPI).[31]*

See sections 1902(a)(10)(E)(i) and 1905(p) of the Act; 42 CFR § 400.200.

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29 Note that Medicare providers cannot charge QMBs for Medicare deductibles, coinsurance, and copays –even if the individual asks to pay them – but may charge any nominal Medicaid copays. See https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf.

30 Under section 1905(p)(1)(A) of the Act, QMBs must either be entitled to Premium-free Part A or entitled to Premium-Part A coverage for individuals age 65 and over. Individuals entitled to Part A solely based on eligibility to enroll as a QDWI. See also 42 CFR § 400.200.

31 Note that while full LIS and the MSP categories use the same resource standard, the resource exclusions applicable to determinations for these programs are not fully aligned. A detailed description of the asset exclusions applied by SSA during LIS eligibility determinations is available at SSA POMS HI 03030.20 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0603030020. States may choose to use the authority granted to them by section 1902(r)(2) of the Act to adopt MSP criteria that better align with those for LIS. For example, states can adopt LIS asset rules that exclude vehicles, the cash value of life insurance and $1,500/$3,000 (for a single individual and married couple, respectively) of burial funds without verifying that such funds have been put in a burial trust.

Current federal income and asset limits for QMB are available at https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html. As described in section 1.6.2, states can modify their financial eligibility methodologies to effectively increase the income or resource standard above the federal floor.

The QMB program is a mandatory eligibility group. The majority of individuals who qualify for QMB also qualify for a separate Medicaid eligibility group that entitles them to the full range of services provided under the state plan, in addition to Medicare cost-sharing assistance.[32]

Under section 1902 (e)(8) of the Act, QMB is effective the month following "the month in which the [QMB] determination first occurs." States have flexibility in applying this provision. States can choose to define "the month in which the QMB determination first occurs" for the QMB coverage group as either: (1) the month that the applicant meets all requirements for QMB or (2) the month in which the eligibility determination is made (if those months are different).

For example, if an individual applies for Medicaid on January 1, and on February 15, the state determines the individual met all of the requirements of QMB in January, the state may either begin QMB coverage on February 1 (i.e., if state elects option one above) or March 1 (i.e., if the state elects option two above).

For QMB-plus individuals determined eligible at application, the separate full-benefit Medicaid coverage may be effective up to three months before the month of application, if the individual received Medicaid covered services and would have been eligible at the time the services were received, even though the same retroactive eligibility period does not apply to their QMB benefits. See 42 CFR § 435.915(a).

1.6.2.2 - Specified Low-Income Medicare Beneficiary (SLMB) Program
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Under the SLMB eligibility group, state Medicaid programs pay the Medicare Part B premiums for individuals who:

- *Are entitled to Medicare Part A (see section 1.1 (including individuals age 65 and over who are entitled to Premium-Part A));*
- *Have income that exceeds 100 percent but is less than 120 percent of the FPL; and*
- *Have resources that do not exceed the full LIS resource standard of three times the SSI resource limit, adjusted annually in accordance with increases in the*

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32 In 2018, 78 percent of QMBs qualified for full-benefit Medicaid in addition to QMB (sometimes referred to as "QMB-plus" individuals), while 22 percent of QMBs qualified for QMB alone (sometimes referred to as "QMB-only" individuals).

CPI.[33]

See sections 1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii) of the Act.

Current federal income and asset limits for SLMB are available at https://www.medicaid.gov/medicaid/eligibility/medicaid-enrolleesAs described in section 1.6.2, states can modify their financial eligibility methodologies and requirements above the federal floor.

Unlike QMBs, the state is precluded from paying the Medicare Part A premiums for SLMBs. Some individuals who qualify for SLMB also qualify for a separate Medicaid eligibility group that entitles them to the full range of services provided under the state plan, in addition to assistance with the Medicare Part B premium.[34]

Coverage for an individual determined eligible under the SLMB group at application may be effective up to three months before the month of application if the individual received Medicaid covered services and would have been eligible at the time services were received. See 42 CFR § 435.916(a).

1.6.2.3 - Qualifying Individuals (QI) Program

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Under the QI eligibility category, state Medicaid programs pay the Medicare Part B premiums for individuals who:

- *Are entitled to Medicare Part A (including individuals age 65 and over who are entitled to Premium-Part A);*
- *Have income that is at least 120 percent, but less than 135 percent, of the FPL; and*
- *Have resources that do not exceed the full LIS resource standard of three times the SSI resource limit, adjusted annually in accordance with increases in the CPI.*[44]

See sections 1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) of the Act.

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33 Note that while full LIS and the MSP use the same resource standard, the resource exclusions applicable to determinations for these programs are not fully aligned. A detailed description of the asset exclusions applied by SSA during LIS eligibility determinations is available at SSA POMS HI 03030.20 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0603030020. States may choose to use the authority granted to them by section 1902(r)(2) of the Act to adopt criteria that better align with those for LIS. For example, states can adopt LIS asset rules that exclude vehicles, the cash value of life insurance and $1,500/$3,000 of burial funds without verifying that such funds have been put in a burial trust.

34 In 2018, 22 percent of SLMBs qualified for full-benefit Medicaid in addition to SLMB (sometimes referred to as “SLMB-plus”), while 78 percent of SLMBs qualified for SLMB alone (sometimes referred to as “SLMB-only”).

Current federal income and asset limits for QIs are available at https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html. As described in section 1.6.2, states can modify their financial eligibility methodologies and requirements above the federal floor.

Like SLMBs, the state is precluded from paying the Medicare Part A premiums for QIs. Similarly, QI determinations may be retroactive for a maximum of three months prior to the month of application within the same calendar year. Unlike QMB and SLMB, individuals who qualify for QI cannot be eligible for a separate eligibility group covered under the state plan. See section 1902(a)(10)(E)(iv).

State Medicaid programs pay for a QI's Medicare Part B premium to the extent their state Medicaid program has available funding. The federal government makes annual allotments to states to fund the Part B premiums. See 1933(g) of the Act.

1.6.3 - All Medicaid Categories

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

In their buy-in agreements, states can elect a Part B buy-in group that includes all individuals eligible for Medicaid under the state plan. This "catch-all" group includes the cash assistance categories and three MSP categories above, plus all other individuals who are eligible for Medicaid, such as the poverty-level group for individuals 65 years old or older (sections 1902(a)(10)(A)(ii)(X); 1902(m)(1) of the Act); the medically needy (section 1902(a)(10)(C) of the Act; 42 CFR § 435.301); and institutionalized individuals eligible under a special income level (section 1902(a)(10)(A)(ii)(V) of the Act; 42 CFR § 435.236).

Generally, the eligibility effective date for Medicaid categories is up to three months before the month of application if all eligibility criteria are met, with exception of the QMB program as described above. See 42 CFR § 435.915. The state is precluded from paying the Medicare Part A premiums for these Medicaid categories.

1.7 - Part A Buy-in Agreement Group - Qualified Medicare Beneficiary (QMB) Program

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Starting January 1, 1990, CMS deemed all buy-in agreements (except in states that opted out), to include the payment of Part A premiums for individuals age 65 or over who meet the requirements for Premium-Part A and are otherwise eligible as QMBs. [35]

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35 CMS (then HCFA) stated, "we informed the States that we would consider all States to have requested modification of their buy-in agreements to cover Part A for QMBs, unless they notified us, by a specified date, that they did not wish to use the buy-in procedure." 56 Fed. Reg. 38074 at 38076 (August 12, 1991).

See section 1.3.2 for more information about eligibility for Premium-Part A and section 1.6.2.1 for more information about QMB.

The majority of states include the payment of premiums for Medicare Part A for QMBs in their agreements and are known as "Part A buy-in states." See section 1.2 for the advantages of a Part A buy-in agreement for states. States that do not include Premium-Part A for QMBs in their state buy-in agreements are known as "group payer states." See the table in appendix 1.D, which classifies states by whether they are a Part A buy-in state or a group payer state as of July 2020.

***NOTE:** States can choose to pay Part A premiums for QMBs through their buy-in agreements or a group payer arrangement. Federal law requires states to pay the Part A premium for QDWIs through the group payer arrangement.*

1.8 - Conversion from Part A Group Payer to Part A Buy-in Status
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

A group payer state may elect to become a Part A buy-in state at any time. See 42 CFR § 406.26(a). Enrollments under a new buy-in agreement can be no earlier than the third month after the month in which the agreement is executed (i.e., formal notification is signed by the state and accepted by CMS). See 42 CFR § 406.26(b).

Interested states should contact the Medicare-Medicaid Coordination Office, who will then coordinate with the state's Center for Medicare and CHIP Services (CMCS) SPA Coordinator and the Division of Premium Billing and Collections in CMS' Office of Financial Management (see contact information in chapter 6).

1.9 - Federal Financial Participation (FFP) for Buy-in Categories
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

States can receive FFP for individuals who are enrolled in the required categories described above and the relevant MSPs. Specifically, states can seek FFP for the state payment of:

- *Medicare Part B premiums, deductibles, coinsurance, and copays for cash assistance recipients (SSI/SSPs) and deemed recipients of cash assistance;*
- *Part A or B premiums, deductibles, coinsurance and copays for QMBs; and*
- *Part B premiums for SLMBs.*

The state's regular FMAP rate applies to these expenditures.[36]

For eligible individuals who are enrolled in any other category of Medicaid, FFP is not available for the state payment of Part B premiums. However, it may be cost-effective for

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36 Note: The federal government funds 100 percent of the Part B premiums for QIs through annual allotments made to states. See section 1933(g) of the Act.

states to include additional categories in their Part B buy-in coverage group since states cannot obtain FFP for state Medicaid expenditures that could have been paid for under Medicare Part B if the person had been enrolled in Part B. See 42 CFR § 431.625(d)(3).

State agencies report gross expenditures (total computable) and apply the applicable FMAP on the Quarterly Expenditure Report for Medical Assistance Payments (Form CMS-64).[37]

States should direct any questions about Form CMS-64 to the analyst within the CMCS Medicaid and CHIP Operations Group (MCOG), Division of Financial Operations (DFO) for their state.

1.10 - Streamlined Enrollment Under a Buy-in Agreement

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Buy-in agreements permit states to enroll members of a buy-in group in Medicare Part A or B and agree to pay their premiums ***at any time of the year (without regard to enrollment periods).*** *CMS does not bill states for any applicable premium surcharges due to late enrollment. See sections 1843 and 1818(g) of the Act.*

In all states, SSA must first determine an individual eligible for Medicare before the state can enroll the individual in buy-in.

If a buy-in group member is neither entitled to Medicare Part A nor enrolled in Part B, *SSA has not yet determined the individual eligible for Medicare. The state should direct the individual to file for Medicare at the SSA Field Office (SSA FO) to enable the state to enroll the person in buy-in.*

If a buy-in group member is entitled to Medicare Part A or is enrolled in Part B, *SSA has established Medicare eligibility for this individual. The state should directly enroll the individual in buy-in without first sending them to file for Medicare at SSA. See section 1.3 for information regarding Medicare eligibility and enrollment.*

Referring an individual to the SSA FO to file a Medicare application for the Part the individual is not already enrolled in is not appropriate. For example, if a member of a group is entitled to Premium-free Part A but is not enrolled in Part B, the state should directly enroll the individual in Part B buy-in without referring them to the SSA FO to file for Part B. Similarly, if a QMB-eligible individual is already enrolled in Part B, a Part A buy-in state should directly enroll that individual in Part A buy-in (without requiring the individual to first file for Part A at the SSA FO). As noted in section 1.11, in group payer states, individuals must always file for Premium-Part A at SSA before the state can enroll them in Part A buy-in.

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37 The expenditures for allowable Medicare Part A premiums are claimed on line 17.A of the Form CMS-64.9 or CMS-64.9P (whichever applies). The expenditures for allowable Medicare Part B premiums are claimed on line 17.B of the Form CMS-64.9 or CMS-64.9P.

1.11 - Conditional Enrollment Process for QMBs to Enroll in Premium-Part A

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Individuals must be entitled to Part A in order to qualify for the QMB program. However, individuals who qualify for the QMB program who are only eligible for Premium-Part A likely cannot afford to pay the Medicare Part A premium without assistance from the QMB program. This creates a predicament for low-income individuals, which SSA's "conditional" Part A enrollment process helps to address.

The conditional enrollment process allows an individual to apply for Premium-Part A at SSA on the condition that he or she only wants coverage if the state approves their QMB application. CMS considers a conditional Part A filing to be sufficient to fulfill the requirement for entitlement to Part A for the purpose of QMB eligibility under section 1905(p)(1)(A) of the Act. If an individual who conditionally files for Part A then applies for the QMB program with their state Medicaid program, the individual can effectively become simultaneously enrolled in Part A and the QMB program if the individual meets all other QMB eligibility requirements.

The conditional enrollment acts as a placeholder in SSA's system. Premium-Part A entitlement is only effective with the individual's enrollment in QMB. The Medicare Part A start date will reflect the QMB start date that the state reports to CMS. If the state does not determine the individual eligible for QMB, SSA will not establish Premium-Part A entitlement.

When processing the conditional Part A enrollment, SSA will refer the individual to the appropriate state Medicaid office to apply for the QMB program and may give the individual a screen shot of the application to bring to the state as proof of the conditional enrollment. The state can also query SSA's State Verification and Exchange System (SVES) to verify the conditional Part A enrollment. See SSA POMS HI 00801.140 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801140 for more information about the conditional enrollment process.

In group payer states, Part A buy-in is always a two-step process. The state cannot determine an individual eligible for QMB and enroll them in Part A buy-in until SSA establishes actual or conditional Part A entitlement. Individuals who do not file for Premium-Part A during their IEP can only file for Premium-Part A during the annual GEP (January through March). If an individual enrolls in Premium-Part A during the GEP, QMB coverage starts July 1 of the calendar year (if the state determines the individual eligible for QMB before July 1), or a month later than July of that year (if the

individual is determined eligible for QMB on July 1 or later).[38] The state pays any premium surcharges.

In Part A buy-in states, if an individual lacks Premium-free Part A, but is already enrolled in Part B (and otherwise qualifies for QMB), the state must enroll the individual in QMB and refrain from referring them to SSA to file for actual or conditional Part A. As mentioned in section 1.10, SSA has established Medicare Part A eligibility for this individual. Since individuals enrolled in Part B meet the requirements for Part A eligibility, they satisfy the requirement to be entitled to Part A for the purposes of the QMB eligibility determination. However, if a QMB applicant lacks Part A and Part B, the state cannot determine the individual eligible for QMB and enroll them in Part A buy-in until SSA establishes actual or conditional Part A enrollment. A conditional Part A filing is sufficient to fulfill the requirement for entitlement to Part A as applicable for QMB coverage. Such individuals can conditionally enroll in Premium-Part A at any time of the year, with no state liability for premium surcharges.

1.12 - Policy Regarding Which Entity Initiates Buy-in
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Depending upon the circumstances, CMS or the state will generally initiate buy-in enrollment ("accretion"). This section describes which entity initiates the accretion.

***NOTE:** Depending upon state procedures, the SSA FO can use a Public Welfare (PW) accretion to initiate Part B buy-in for individuals who file a Part B application and appear to qualify for Part B buy-in. Enrolling the individual in Part B through buy-in protects the beneficiary from paying premiums through deductions from SSA or RRB or by direct bill, which is mailed to the beneficiary by CMS. See chapter 2, section 2.8 for more information about PW accretions.*

1.12.1 - Part B Buy-in for Cash-Related Recipients (SSI/SSPs)
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

SSA regularly communicates with states regarding who is entitled to SSI and/or federally-administered SSPs through SSA data systems, such as the State Data Exchange (SDX). See chapter 2, section 2.4.2 for a list of SSA systems for states. In addition, SSA sends information to CMS about SSI/SSPs recipients who qualify for Medicare which, in turn, assists states in enrolling cash recipients in Part B buy-in. See chapter 2, section 2.5.1.1 for more information.

The state is responsible for accreting individuals the state has found eligible for Medicaid in the SSI criteria category to the state's buy-in rolls.

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38 If the state determines the individual eligible in June of that year, QMB coverage can start as early as July 1.

In auto-accrete states and states with 1616 agreements, *CMS automatically accretes individuals in Part B buy-in only after SSA notifies CMS that the individual is entitled to SSI and eligible for Medicare. In states with 1616 agreements, CMS will auto-accrete individuals who receive SSI only, or SSI in combination with SSPs, or SSPs-only.*

NOTE: *Although CMS generally initiates auto-accretions for these individuals, the state is responsible for taking action to ensure all eligible individuals are enrolled in Part B buy-in.*

In alert states (SSI Criterion and 209(b) states (states that apply stricter eligibility criteria than SSI)), CMS sends states "SSI alert notification" records for SSI individuals who are also eligible for Medicare. The state is responsible for accreting individuals the state has found eligible for Medicaid in the SSI criteria category to the state's buy-in rolls.

States must always initiate:

- *Part A or B buy-in for QMBs;*
- *Part A buy-in for QDWIs;*
- *Part B buy-in for deemed recipients of cash assistance;*
- *Part B buy-in for SLMB and QI; and*
- *Part B buy-in for other full-benefit Medicaid recipients.*

1.13 - Definition of Part B Buy-in Coverage Period (See Appendix 1.C)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

1.13.1 - Beginning of Part B Buy-in Coverage (42 CFR § 407.47)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

For an individual enrolled in the Required Categories (i.e., cash assistance recipients or deemed recipients of cash assistance) or the three MSPs, Part B buy-in begins the later of:

- *The first month in which the individual meets the requirements both for eligibility in the buy-in group (i.e., the effective date of the individual's full-benefit Medicaid or MSP coverage) and eligibility for Medicare Part B; or*
- *The first month in which the individual meets the requirements both for eligibility in the buy-in group (i.e., the effective date of the individual's full-benefit Medicaid or MSP coverage) and eligibility in the buy-in group (i.e., the effective date of the individual's full-benefit Medicaid or MSP coverage) and eligibility for Medicare Part B; or*
- *The effective date of the buy-in agreement or modification that includes the buy-in group to which the individual belongs (defined as the third month after the document's execution).*

For an individual enrolled in one of the other Medicaid categories (e.g., the buy-in group includes all Medicaid categories), Part B buy-in begins the later of:

- *The second month after the individual meets the requirements both for eligibility in the buy-in group (i.e., the effective date of the individual's Medicaid coverage) and eligibility for Medicare Part B; or*
- *The effective date of the buy-in agreement or modification that includes the buy-in group to which the individual belongs (defined as the third month after the document's execution).*

To determine the effective date of Part B buy-in, a state must consider all bases of membership in the buy-in group. If a state determines an individual eligible for QMB-plus or SLMB-plus, Part B buy-in begins the earlier of the buy-in effective date applicable to the Medicaid or MSP categories.

To illustrate, for a QMB-plus individual, the start of Part B buy-in coverage is often earlier than the QMB effective date. For example:

If an individual is enrolled in a required category (e.g., SSI) effective April 1 and the QMB effective date is August 1, Part B buy-in starts on April 1 (i.e., the buy-in start date for required categories).

If an individual is enrolled in one of the other Medicaid categories effective April 1 and the QMB effective date is August 1, Part B buy-in starts on June 1 (i.e., the buy-in start date for other Medicaid categories).

1.13.2 - End of Part B Buy-in Coverage (42 CFR § 407.48)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Part B buy-in coverage ends with the earliest of the events specified below:

- ***Death –** Coverage ends on the last day of the month in which the individual dies.*

- ***Loss of enrollment in Medicare Part A –** If an individual is under age 65 and is no longer enrolled in Medicare Part A (i.e., no longer qualifies for SSA Disability benefits), Part B buy-in ends on the last day of the last month for which the individual is enrolled in Part A.*

- ***Termination or modification of the buy-in agreement –** If the state's buy-in agreement is terminated or modified to restrict coverage to a narrower buy-in group, coverage for an individual ends on the last day of the last month for which the agreement is in effect or covers the broader group.*

- ***Loss of membership in the buy-in group –** The last day of the month in which the individual is enrolled in one or more Medicaid categories under the buy-in group.*

CMS may modify the effective date of the deletion requested by the state based on CMS system processing rules that limit the retroactivity of Part B deletions to two months prior to the "processing month." See 42 CFR § 407.48(c). To learn more about CMS processing limits intended to prevent excessive hardship for beneficiaries, see chapter 2,

section 2.6.1.3.

States must redetermine eligibility and continue buy-in coverage without interruption if the individual qualifies for another Medicaid category covered under the buy-in agreement. See section 1.4 for state requirements when an individual loses eligibility for a buy-in group category.

1.14 - Definition of Part A Buy-in Coverage Period (42 CFR § 406.26) (See Appendix 1.C)

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

1.14.1 - Beginning of Part A Buy-in Coverage

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Part A buy-in begins the later of:

- *The effective date of the buy-in agreement or modification that covers QMBs (defined as the third month after the document's execution); or*
- *The month the individual is enrolled in Premium-Part A and QMB. See appendix 1.C for the effective date of QMB.*

NOTE: *SSA's conditional enrollment process allows individuals to meet the eligibility criterion for the QMB program (entitlement in Part A), enabling states to determine them eligible for QMB and buy them into Part A. See section 1.11 for information about SSA's conditional enrollment process for QMB-eligible individuals.*

1.14.2 - End of Part A Buy-in Coverage

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Part A buy-in coverage ends with the earliest of the events specified below:

- ***Death*** *– Coverage ends on the last day of the month in which the individual dies.*

- ***Enrollment in Premium-free Part A*** *– If an individual enrolls in Premium-free Part A, Part A buy-in coverage ends on the last day of the last month the individual is enrolled in Premium-Part A.*

- ***Termination of the Part A buy-in agreement*** *– If the state terminates its Part A buy-in agreement (i.e., removes the payment of Part A premiums for QMB from the buy-in agreement), coverage through the buy-in agreement will end. However, payment of the Part A premiums for QMB individuals must continue under the group payer arrangement.*

- ***Loss of QMB status*** *– The last day of the month in which the individual is enrolled in QMB.*

CMS may modify the effective date of the deletion requested by the state based on the CMS regulation that limits the Part A deletion date to the month CMS processes the deletion. See 42 CFR § 406.26. To learn more about CMS processing of Part A deletion requests for individuals who lose QMB status, see chapter 2, section 2.6.1.4.

1.15 - Implications and Options for Beneficiaries When State Buy-in Coverage Ends

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

When a state stops paying the Part A or Part B premium for an individual, Medicare enrollment continues without interruption, with the beneficiary assuming responsibility for paying the premiums. See 42 CFR §§ 406.26(d) and 407.50(a).

- *Premiums paid under a state buy-in agreement: The beneficiary is deemed to have enrolled during the IEP and is liable for the standard base premium amount even if they had been paying a premium surcharge prior to enrollment in buy-in.*

- *Premiums paid under state group payer arrangement: The beneficiary becomes liable for the premium amount the state paid (i.e., the Medicare Part A premium may be subject to a premium surcharge if the state had been paying one).*

If the beneficiary receives Social Security (OASDI or SSI)RRBor Civil Service Retirement benefits, SSA will typically deduct the Part A and/or B premium amount for their monthly benefit payment. If the beneficiary does not receive Social Security, RRB or Civil Service Retirement benefits (or their benefit is less the premium amount owed), they will receive bills from CMS or SSA ("direct billing") for Medicare Part A and/or B premiums.[39] Once the state ends buy-in coverage, SSA will send the beneficiary a notice of state buy-in termination ("buy-out notice").

1.15.1 - Voluntary Withdrawal (Termination) From Medicare

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

The buy-out notice describes the option to withdraw from Medicare Part A and/or Part B and encloses a ***Request for Termination of Premium Hospital and/or Supplemental Medical Insurance*** *(Form CMS-1763) that the beneficiary can file to terminate Medicare coverage. See appendix 1.E for the process of voluntary termination when buy-in ends and appendix 1.F for copy of Form CMS-1763.*

- *If the beneficiary files Form CMS-1763 within 30 days of the buy-out notice date, Part A and/or B will generally terminate the month buy-in has ended.*

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39 Part B premiums are billed quarterly, whereas Part A alone and Part A and Part B combined are billed monthly. A grace period for premium payment extends until the end of the third month of unpaid premiums; after 90 days the direct billing notice will include a termination date of coverage.

NOTE: *The notice may be dated after buy-in has already terminated.*

- *If the beneficiary files Form CMS-1763 during the six months following the loss of buy-in (group payer coverage), Medicare coverage ends at the end of the month in which the beneficiary filed the notice.*

- *If a beneficiary waits more than six months after buy-in (group payer) coverage ends to file Form CMS-1763, coverage ends at the end of the month after the month in which the beneficiary notifies SSA or CMS that they wish to withdraw.*

1.15.2 - Options for Financial Relief from Retroactive Part B Premium Billing

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

SSA may initially bill beneficiaries for Part B premium liability amounts of up to three months (current month plus two retroactive billing months) when Part B buy-in coverage ends. See 42 CFR § 407.48(c) and chapter 2, section 2.6.1.3. Beneficiaries have two options to obtain financial relief from retroactive Part B premium billing.

- *Premium Waiver - Beneficiaries who believe they cannot afford to pay the retroactive premiums can request a premium waiver by submitting a Request for Waiver of Overpayment Recovery, available at https://www.ssa.gov/forms/ssa-632-bk.pdf to their local SSA office. If SSA grants the waiver request and has already deducted retroactive Medicare premiums from the beneficiary's benefit payment, SSA will refund the waived amount to the beneficiary. See SSA POMS HI 00830.15 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600830015 for more information about retroactive premium waivers.*

- *Installment Payments for Retroactive Premiums - Beneficiaries may request an installment plan from their local SSA office if they indicate they cannot afford to pay the retroactive premiums in one lump sum and a waiver is not possible. Installment payments must be at least $20 per month. For more information about installment payments, see SSA POMS HI 00830.060 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600830060.*

Appendix 1.A- Dual Eligibility Categories and Assistance with Medicare Part A and Part B Costs

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Category	*Monthly Income**	*Assets **	*Covers Part A premium (when applicable)*	*Covers Part B premium*	*Covers Parts A and B cost-sharing*	*Full-benefit Medicaid coverage***
QMB-only	*FPL ≤ 100%*	*≤3 times the SSI resource limit, adjusted based on the CPI*	*X*	*X*	*X****	
*QMB plus***	*FPL ≤ 100%*	*States determine resources criteria*	*X*	*X*	*X****	*X*
SLMB-only	*> 100% FPL < 120%*	*≤3 times the SSI resource limit, adjusted based on the CPI*		*X*		
*SLMB plus***	*> 100% FPL < 120%*	*≤3 times the SSI resource limit, adjusted based on the CPI*		*X*	*Depends on state plan*****	*X*
QI	*≥ 120% FPL < 135%*	*<3 times the SSI resource limit, adjusted based on the CPI*		*X*		

Category	Monthly Income*	Assets *	Covers Part A premium (when applicable)	Covers Part B premium	Covers Parts A and B cost-sharing	Full-benefit Medicaid coverage**
QDWI	≤200% FPL	≤2 times the SSI resource limit	X			
Full-benefit Medicaid (only)**	Determined by state	Determined by state		Depends on state Buy-in Agreement****	Depends on state plan*****	X

** The income and asset limits for the MSPs are released annually by CMS. The income limit for QDWI includes an earned income disregard of $65. The asset limit calculation for QMBs, SLMBs, and QIs is three times the SSI resource limit, adjusted annually by increases in the CPI (effective January 1, 2010). States can effectively raise the federal floor for income and resources standards under the authority of section 1902(r)(2) of the Social Security Act, which generally permits state Medicaid agencies to disregard income and/or resources that are counted under certain standard financial eligibility methodologies. Some states have used the authority of section 1902(r)(2) of the Act to eliminate any resource criteria for the MSP groups.*

*** "Full-benefit" Medicaid coverage generally refers to coverage for a range of items and services, beyond coverage for Medicare premiums and cost-sharing, that certain individuals are entitled to when they qualify under certain eligibility categories included in the state plan. Individuals who are QMB/SLMB "plus" receive full-benefit Medicaid in addition to Medicare cost-sharing and premiums coverage. Individuals who receive full-benefit Medicaid only are entitled to Medicare Part A and/or enrolled in Part B, and qualify for full-benefit Medicaid benefits, but not the QMB or SLMB programs*

**** While individuals enrolled in QMB do not pay Medicare deductibles, coinsurance, or copays, they may have a small Medicaid copay for certain Medicaid-covered services.*

***** States pay the Part B premiums if they include all Medicaid categories in their Part B buy-in coverage group.*

****** Beneficiary pays no more than the amount allowed by the state plan for services covered by both Medicare and Medicaid if the provider participates in Medicaid. Also, all Medicare providers (regardless of Medicaid participation) must accept the Medicare-allowed amount as payment in full for Part B services furnished to dual eligible beneficiaries*

Appendix 1.B- Dual Eligibility Category Descriptions
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB-Only – also known as QMB "partial-benefit") *are enrolled in Medicare Part A (or if uninsured for Part A, have filed for Premium-Part A on a conditional basis), have income up to 100 percent of the federal poverty level (FPL) and resources that do not exceed three times the limit for supplementary security income (SSI) eligibility with adjustments for inflation, and are not otherwise eligible for full-benefit Medicaid coverage. Medicaid pays their Medicare Part A premiums, if any, and Medicare Part B premiums. Medicare providers may not bill QMBs for Medicare Parts A and B cost-sharing amounts, including deductibles, coinsurance and copays. Providers can bill Medicaid programs for these amounts, but states have the option to reduce or eliminate the state's Medicare cost-sharing payments by adopting policies that limit payment to the lesser of (a) the Medicare cost-sharing amount, or (b) the difference between the Medicare payment and the Medicaid rate for the service.*

QMBs with full-benefit Medicaid (QMB-Plus – also known as QMB "full-benefit") *meet the QMB-related eligibility requirements described above and the eligibility requirements for a separate categorical Medicaid eligibility group covered under the state plan. In addition to the coverage for Medicare premiums and cost-sharing described above, QMB-plus individuals receive the full range of Medicaid benefits applicable to the separate eligibility group for which they qualify. Medicaid pays their Medicare Part A premiums, if any, and Medicare Part B premiums. Medicare providers may not bill QMBs for Medicare Parts A and B cost-sharing amounts, including deductibles, coinsurance and copays. Providers can bill Medicaid programs for these amounts, but states have the option to reduce or eliminate the state's Medicare cost-sharing payments by adopting policies that limit payment to the lesser of (a) the Medicare cost-sharing amount, or (b) the difference between the Medicare payment and the Medicaid rate for the service. QMBs with full-benefit Medicaid pay no more than the Medicaid coinsurance[40] (if applicable) for services covered in the state plan (i.e., care that is furnished by a Medicaid provider and that either: (1) Medicare and Medicaid, or (2) Medicaid, but not Medicare, cover). These individuals pay Medicare cost-sharing for Medicare-covered care not included in the state plan, unless the state chooses to pay these costs.*

Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB-Only – also known as SLMB "partial-benefit") *are enrolled in Part A and have income between 100 and 120 percent of the FPL, and resources that do not exceed three times the limit for supplementary security income (SSI) eligibility with adjustments for inflation. Medicaid pays only the Medicare Part B premiums for this group.*

Specified Low-Income Medicare Beneficiaries (SLMBs) with full-benefit Medicaid (SLMB-Plus – also known as SLMB "full-benefit") *meet the SLMB-related eligibility requirements*

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40 States may apply cost-sharing, such as copayments, deductibles, and/or premiums, to certain Medicaid beneficiaries in accordance with 42 CFR §§ 447.52 to 447.56.

described above, and the eligibility requirements for a separate categorical Medicaid eligibility group covered under the state plan. In addition to coverage for Medicare Part B premiums, these individuals receive full-benefit Medicaid coverage (i.e., the package of benefits provided to the separate Medicaid eligibility group for which they qualify). These individuals pay no more than the Medicaid coinsurance[41] (if applicable) for services covered in the state plan (i.e., care that is furnished by a Medicaid provider and that either: (1) Medicare and Medicaid, or (2) Medicaid, but not Medicare, cover.) These individuals pay Medicare cost-sharing for Medicare-covered care not included in the state plan, unless the state chooses to pay these costs.

***Qualifying Individuals (QIs)** are enrolled in Part A and have income of at least 120 but less than 135 percent of the FPL, and resources that do not exceed three times the limit for SSI eligibility with adjustments for inflation. QIs may not be eligible for a separate eligibility group covered under the state plan. QIs receive coverage for their Medicare Part B premiums, to the extent their state Medicaid programs have available funding. The federal government makes annual allotments to states to fund the Part B premiums.*

***Qualified Disabled and Working Individuals (QDWIs – also known as QDWI "partial-benefit")** became eligible for Premium-free Part A by virtue of qualifying for Social Security Disability Insurance (SSDI) benefits, but lost those benefits, and consequently Premium-free Medicare Part A, because they returned to work. QDWIs have income that does not exceed 200 percent of the FPL, resources that do not exceed two times the SSI resource standard, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.*

***Full-benefit Medicaid Only:** These individuals are entitled to Medicare Part A and/or enrolled in Part B, and qualify for full Medicaid benefits, but not the QMB or SLMB programs. Full-benefit Medicaid coverage refers to the package of services, beyond coverage for Medicare premiums and cost-sharing, that certain individuals are entitled to when they qualify under eligibility categories covered under a state's Medicaid program. Some of these coverage categories are ones states generally must cover (for example, SSI recipients) and some are ones states have the option to cover (for example, the "special income level" group for institutionalized individuals, home and community based services (HCBS) participants, and "medically needy" individuals). Some of the services covered by Medicaid are ones Medicare does not cover, such as certain long-term services and supports (LTSS), certain behavioral health, transportation, and vision services. Medicaid benefits vary by state. A full-benefit Medicaid beneficiary pays no more than the Medicaid coinsurance[42] (if applicable) for services covered in the state plan (i.e., care that is furnished by a Medicaid provider and that either: (1) Medicare and Medicaid, or (2) Medicaid, but not Medicare, cover.) These individuals pay Medicare cost-sharing for Medicare-covered care not included in the state plan, unless the state chooses to pay these costs.*

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41 States may apply cost-sharing, such as copayments, deductibles, and/or premiums, to certain Medicaid beneficiaries in accordance with 42 CFR §§ 447.52 to 447.56.

42 States may apply cost-sharing, such as copayments, deductibles, and/or premiums, to certain Medicaid beneficiaries in accordance with 42 CFR §§ 447.52 to 447.56.

Appendix 1.C- Medicaid Effective Dates and Buy-in Start and Stop Dates

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Medicaid Category	***Medicaid category effective date is up to three months before the month of application*** ***42 CFR § 435.915(a)***	***Medicaid category effective date is the month after the eligibility requirements are met***** ***Section 1902(e)(8) of the Act***	***Part B buy-in starts the month an individual qualifies for Medicare and is a member of the coverage group**** ***42 CFR § 407.47(a)-(c)***	***Part B buy-in starts the second month after an individual qualifies for Medicare and is a member of the coverage group**** ***42 CFR § 407.47(d)***	***Part A buy-in starts the month an individual is enrolled in Medicare Part A and has QMB status***** ***42 CFR § 406.26(b)***	***Part B buy-in deletion due to loss of coverage group membership, is effective the month after coverage group membership ends ****** ***42 CFR § 407.48(c)***	***Part A buy-in deletion based on loss of QMB status is effective the month after QMB ends ******* ***42 CFR § 406.26 (c)(2)***
Cash assistance (SSI/SSPs) and deemed recipients of cash assistance who are categorically needy	*X*		*X*			*X*	
QMB		*X*	*X*		*X* *In Group Payer states only:* *As early as July 1 of any given year in which actual or conditional Part A application occurred*	*X*	*X*

Medicaid Category	***Medicaid category effective date is up to three months before the month of application*** ***42 CFR § 435.915(a)***	***Medicaid category effective date is the month after the eligibility requirements are met***** ***Section 1902(e)(8) of the Act***	***Part B buy-in starts the month an individual qualifies for Medicare and is a member of the coverage group**** ***42 CFR § 407.47(a)-(c)***	***Part B buy-in starts the second month after an individual qualifies for Medicare and is a member of the coverage group**** ***42 CFR § 407.47(d)***	***Part A buy-in starts the month an individual is enrolled in Medicare Part A and has QMB status**** ***42 CFR § 406.26(b)***	***Part B buy-in deletion due to loss of coverage group membership, is effective the month after coverage group membership ends ***** ***42 CFR § 407.48(c)***	***Part A buy-in deletion based on loss of QMB status is effective the month after QMB ends ****** ***42 CFR § 406.26 (c)(2)***
					during the GEP.		
SLMB	*X*		*X*			*X*	
QI	*X*		*X*			*X*	
Other Full-benefit Medicaid Eligibility Categories	*X*			*X*		*X*	

**This date applies if a buy-in agreement is already in effect; currently, all states include MSPs in their Part B buy-in agreements. Thirty-six states and DC have Part A buy-in agreements.*

*** An individual in a Group Payer state who must enroll in Premium-Part A but has missed their IEP, must enroll in Premium-Part A (conditionally or unconditionally) during the GEP. If the state determines the individual eligible for QMB in June of that year, QMB can start July 1.*

**** CMS may modify the effective date of the Part B deletion requested by the state because CMS limits the retroactivity of Part B deletions to two months prior to the "processing month." See chapter 2, section 2.6.1.3.*

***** CMS may modify the effective date of the Part A deletion requested by the state because CMS limits the Part A deletion date to the month CMS processes the deletion. See chapter 2, section 2.6.1.4.*

Appendix 1.D - Classification of States by SSI and Part A Status as of July 2020
(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

State	*SSI Status Accrete or Alert*	*Part A Buy-in*	*Part A Group Payer*[43]
Alabama	*Accrete*		*X*
Alaska	*Alert (SSI-criterion)*	*X*	
Arizona	*Accrete*		*X*
Arkansas	*Accrete*	*X*	
California	*Accrete*		*X*
Colorado	*Accrete*		*X*
Connecticut	*Alert (209b)*	*X*	
Delaware	*Accrete*	*X*	
District of Columbia	*Accrete*	*X*	
Florida	*Accrete*	*X*	
Georgia	*Accrete*	*X*	
Hawaii	*Alert (209b)*	*X*	
Idaho	*Alert (SSI-criterion)*	*X*	
Illinois	*Alert (209b)*		*X*
Indiana	*Accrete*	*X*	
Iowa	*Accrete*	*X*	
Kansas	*Alert (SSI-criterion)*		*X*
Kentucky	*Accrete*		*X*
Louisiana	*Accrete*	*X*	
Maine	*Accrete*	*X*	
Maryland	*Accrete*[44]	*X*	
Massachusetts	*Accrete*	*X*	
Michigan	*Accrete*	*X*	
Minnesota	*Alert (209b)*	*X*	
Mississippi	*Accrete*	*X*	

43 States can choose to pay Part A premiums for QMBs through their buy-in agreements or a group payer arrangement. Federal law requires states to pay the Part A premiums for QDWIs through the group payer arrangement.

44 Although Maryland has a 1634 agreement, CMS does not auto-accrete SSI recipients who are Medicare-eligible in Part B buy-in. Instead, Maryland initiates Part B buy-in enrollment for Medicare-eligible SSI recipients.

State	*SSI Status Accrete or Alert*	*Part A Buy-in*	*Part A Group Payer*[43]
Missouri	*Alert (209b)*		*X*
Montana	*Accrete*	*X*	
Nebraska	*Alert (SSI-criterion)*		*X*
Nevada	*Alert (SSI-criterion)*	*X*	
New Hampshire	*Alert (209b)*	*X*	
New Jersey	*Accrete*		*X*
New Mexico	*Accrete*		*X*
New York	*Accrete*	*X*	
North Carolina	*Accrete*	*X*	
North Dakota	*Alert (209b)*	*X*	
Ohio	*Accrete*	*X*	
Oklahoma	*Alert (209b)*	*X*	
Oregon	*Alert (SSI-criterion)*	*X*	
Pennsylvania	*Accrete*	*X*	
Rhode Island	*Accrete*	*X*	
South Carolina	*Accrete*		*X*
South Dakota	*Accrete*	*X*	
Tennessee	*Accrete*	*X*	
Texas	*Accrete*	*X*	
Utah	*Alert (SSI-criterion)*		*X*
Vermont	*Accrete*	*X*	
Virginia	*Alert (209b)*		*X*
Washington	*Accrete*	*X*	
West Virginia	*Accrete*	*X*	
Wisconsin	*Accrete*	*X*	
Wyoming	*Accrete*	*X*	

Appendix 1.E - Implications and Options for Beneficiaries Who Lose Buy-in Coverage

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

Voluntary Termination/Withdrawal from Medicare Part A and/or B	
Process to terminate coverage *SSA POMS HI 00820.901 (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600820901)*	• *The "buy-out" notice from SSA, includes the Request for Termination of Premium Hospital and/or Supplemental Medical Insurance (Form CMS-1763) that the beneficiary must file to terminate Medicare coverage. See Appendix 1.F for copy of Form CMS-1763* • *On the form the beneficiary must specify termination of Part A (Premium-HI Hospital Insurance) or both Premium-HI and Part B (SMI Medical Insurance)*
Terminating coverage when state buy-in ends *SSA POMS HI 00820.015 (Premium-Part A) (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600820015)* *SSA POMS HI 00815.042 (Part B) (https://secure.ssa.gov/poms.nsf/lnx/0600815042)*	• *If the beneficiary files Form CMS-1763 to withdraw from Premium-Part A within 30 days of the buy-out notice date, Premium-Part A will terminate the month state buy-in ends*
Withdrawals after the state buy-in ends *SSA POMS HI 00820.015 (Premium-Part A) (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600820015)* *SSA POMS HI 00815.042 (Part B) (https://secure.ssa.gov/poms.nsf/lnx/0600815042)*	• *If the beneficiary files Form CMS-1763 within six months after a state buy-out, but not within 30 days of the buy-out notice, Premium-Part A enrollment through the end of the month.*
Terminating coverage six months or more after state buy-in ends	• *If the beneficiary files Form CMS-1763 to withdraw from Premium-Part A more than six months after state buy-in ends, the Premium-Part A termination is effective at the end of the month after the month the beneficiary files for withdrawal.*

Voluntary Termination/Withdrawal from Medicare Part A and/or B	
	NOTE: *In group payer states, withdrawals after buy-out will be assigned a Premium A termination date equal to two months after the date of the requested month.*

Options for Financial Relief from Retroactive Part B Premium Billing	
Premium Waiver *SSA POMS HI 00830.015 (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600830015)*	• *If beneficiaries cannot afford to pay the retroactive premiums, they can request relief by submitting a Request for Waiver of Overpayment Recovery, available at https://www.ssa.gov/forms/ssa-632-bk.pdf, to their local SSA office. If SSA grants the waiver request and has already deducted retroactive Medicare premiums from the beneficiary's benefit payment, SSA will refund the waived amount to the beneficiary.*
Installment Payments for Retroactive Premiums *SSA POMS HI 00830.060 (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600830060)*	• *Beneficiaries may request an installment plan from their local SSA office if they indicate they cannot afford to pay the retroactive premiums in one lump sum, and a waiver is not possible. Installment payments must be at least $20 per month.*

Appendix 1.F - Request for Termination of Premium Hospital and/or Supplemental Medical Insurance

(Rev. 4, Issued: 08-21-20, Effective: 09-08-20, Implementation: 09-08-20)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0025 (Expires: 05/21)

REQUEST FOR TERMINATION OF PREMIUM HOSPITAL AND/OR SUPPLEMENTARY MEDICAL INSURANCE

DO NOT WRITE IN THIS SPACE

The completion of this form is needed to document your voluntary request for termination of Medicare coverage as permitted under the Code of Federal Regulations. Section 1838(b) and 1818A(c)(2)(B) of the Social Security Act require filing of notice advising the Administration when termination of Medicare coverage is requested. While you are not required to give your reasons for requesting termination, the information given will be used to document your understanding of the effects of your request.

NAME OF ENROLLEE *(Please Print)*		MEDICARE NUMBER	
NAME OF PERSON, IF OTHER THAN ENROLLEE, WHO IS EXECUTING THIS REQUEST.	**THIS IS A REQUEST FOR TERMINATION OF** ☐ HOSPITAL INSURANCE ☐ MEDICAL INSURANCE	**DATE SUPPLEMENTARY MEDICAL INSURANCE WILL END**	**DATE HOSPITAL INSURANCE WILL END**

I request termination of my enrollment under the above sections of title XVIII of the Social Security Act, as amended, for the reason(s) stated below:

I UNDERSTAND THAT IF I AM REQUIRED TO PAY FOR MY HOSPITAL INSURANCE, THE TERMINATION OF MY SUPPLEMENTARY MEDICAL INSURANCE COVERAGE WILL ALSO END MY HOSPITAL INSURANCE COVERAGE.

If this request has been signed by mark (X), two witnesses who know the applicant must sign below, giving their full addresses.	**SIGNATURE** *(Write in Ink)* **SIGN HERE**
1. NAME OF WITNESS	
ADDRESS *(Number and Street, City, State and Zip Code)*	**MAILING ADDRESS** *(Number and Street)*
2. NAME OF WITNESS	**CITY, STATE, ZIP CODE**
ADDRESS *(Number and Street, City, State and Zip Code)*	**DATE** *(Month, Day and Year)* / **TELEPHONE NUMBER**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0025. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Form CMS-1763

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R4SPMP	08/21/2020	New State Payment of Medicare Premiums, (SPMP)	09/08/2020	N/A