Assessing the Fiscal Viability of a Medicare Part A Buy-in Agreement in Group Payer States

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As of December 2021, 14 states do not yet have a Medicare Part A buy-in agreement with the Centers for Medicare & Medicaid Services (CMS).[1] Assessing the impact of newly implementing a Medicare Part A buy-in agreement for the Qualified Medicare Beneficiary (QMB) eligibility group is complex.[2] This tool is designed to help states without Part A buy-in agreements – known as "group payer" states – understand how to use their own data to analyze the potential costs and benefits of entering into such an agreement.

Executing a Part A buy-in agreement with CMS may produce both new state costs and new forms of savings.[3] For example, the costs of increased QMB enrollment may be offset by increased enrollment in Medicare Part A, which pays first for services like inpatient hospital care, skilled nursing facility care, hospice, and some home health care. Part A buy-in agreements may also produce savings by removing state liability for Part A late-enrollment premium penalties, increasing enrollment in Medicare-Medicaid integrated care plans, and reducing state administrative burden. See the box **Drivers of State Costs and Savings from Part A Buy-in Agreements** for a list of key factors driving potential costs and savings related to the execution of a Part A buy-in agreement.

Drivers of State Costs and Savings from Part A Buy-in Agreements

Key drivers of new state costs associated with execution of a Part A buy-in agreement include:

- Number of individuals in the state eligible for Premium-Part A* and QMB but not enrolled in either
- Proportion of Premium-Part A and QMB-eligible (but not enrolled) individuals who owe full vs. reduced Part A premiums
- Proportion of Premium-Part A and QMB-eligible (but not enrolled) individuals who do not currently have Medicaid coverage

Key drivers of savings associated with execution of a Part A buy-in agreement include:

- Moving to Medicare the cost of care for Medicare-covered items and services provided to Medicaid enrollees who are QMB-eligible but not enrolled and who owe a premium for Part A (or would if they were enrolled in Part A)
- State Medicaid provider payment rates and use of fee-for-service or managed care delivery systems
- The number of QMB enrollees and QMB-eligible individuals who owe Part A premium penalties

*Individuals who are age 65 or over and do not have the requisite work credits to qualify for premium-free Part A may qualify to enroll in Part A with a monthly premium if they meet certain requirements. For more information, see Chapter 1 of the Manual for State Payment of Medicare Premiums.

QMB-Eligible Populations

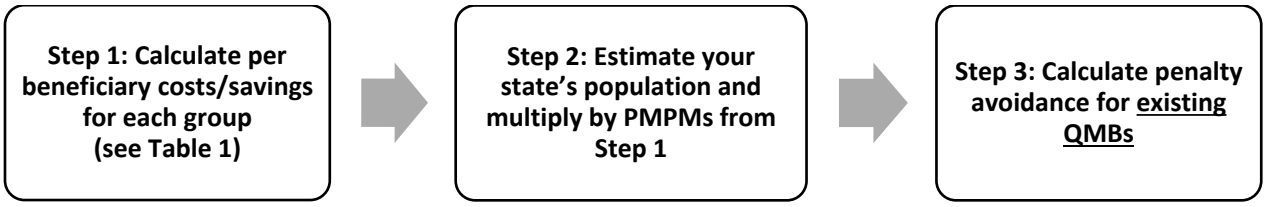
The potential costs and savings vary based on the current Medicare and Medicaid enrollment status of a state's QMB-eligible individuals. The tool identifies four distinct populations of beneficiaries who are eligible for Premium-Part A and QMB, but not yet enrolled:[4] (1) those with Medicaid and Medicare Part B;[5] (2) those with Medicaid but no Part B; (3) those without Medicaid who have Part B; and (4) those without Medicaid or Part B. For a particular state, the costs and savings of executing a Part A buy-in agreement will depend on the size and ratio of these different populations.

More details about each of these populations and the potential costs and savings associated with enrolling them in QMB are provided in **Appendices A and B**. In addition, the Integrated Care Resource Center (ICRC) is available to provide technical assistance on behalf of CMS to states interested in assessing the fiscal viability of the buy-in process. Request technical assistance at ICRC@chcs.org.

Calculation Steps

States can calculate the estimated costs and savings of executing a Part A buy-in agreement using a three-step process as illustrated in **Figure 1** and described below.

Figure 1. Calculation Steps for Estimating Costs/Savings of Executing a Part A Buy-in Agreement



Step 1: Calculate potential costs and savings per beneficiary per month (referred here to as per member per month (PMPM)) for each population group eligible for, but not enrolled in, Premium-Part A and QMB.

Table 1 (next page) illustrates how a state can calculate its PMPM costs and savings for each population group of individuals who are eligible for Premium-Part A and QMB, but not enrolled. States can also use ICRC's editable versions of Tables 1, 2, and 3 for their own calculations. For details about the illustrative amounts displayed in Table 1, see Appendix A (costs) and Appendix B (savings).

Table 1. Illustrative Calculation of PMPM Costs and Savings for Members New to Part A and QMB

	Medicaid and Medicare Part B	Medicaid but no Medicare Part B	No Medicaid but with Medicare Part B	No Medicaid, no Medicare Part B
Expected Costs				
Part A Premiums PMPM[1]	$447.68	$447.68	$447.68	$447.68
Part B Premiums PMPM[2]	-	$148.50	$148.50	$148.50
Part A Cost Sharing PMPM[3]	$24.79	$24.79	$24.79	$24.79
Part B Cost Sharing PMPM[3]	$58.71	$58.71	$58.71	$58.71
Total Costs PMPM	**$531.19**	**$679.69**	**$679.69**	**$679.69**
Expected Savings				
Premium Penalty Avoidance PMPM for New QMB Enrollees[4]	$11.75	$11.75	$11.75	$11.75
Medicare-Covered Services PMPM[5]	$581.00	$1,000.00	-	-
Medicare-Medicaid Integration Savings PMPM[6]	$15.00	$15.00	$15.00	$15.00
Administrative Savings PMPM[7]	$2.00	-	$2.00	-
Total Savings PMPM	**$609.75**	**$1,026.75**	**$28.75**	**$26.75**
Net Expected Savings (Costs) PMPM	**$78.56**	**$347.06**	**$(650.94)**	**$(652.94)**

Notes:

[1] **Part A Premiums.** States pay Medicare Part A premiums for QMB enrollees through their Medicaid programs, so an increase in QMB enrollment increases state Part A premium costs. Part A premiums generally increase each year and are **not state specific.** Nationally, CMS has estimated that in 2021, 89% of individuals enrolled in Premium-Part A owe a full premium ($471/month) and 11% owe a reduced premium ($259/month). This averages to **$447.68 per member per month,** which is described in more detail in Appendix A. **The percentage of people for whom states would pay a full vs reduced premium will vary by state.**

[2] **Part B Premiums.** States also pay Medicare Part B premiums for QMB enrollees **($148.50 PMPM in 2021**); however, new QMB enrollees with full Medicaid benefits will not create new costs, as states will already be covering Part B premiums and/or Medicaid benefits for those individuals. **Part B premiums generally increase each year and will not vary by state.**

[3] **Medicare Cost Sharing.** States may also incur new expenses for covering Medicare cost sharing for individuals who enroll in QMB after the state executes a Part A buy-in agreement. **The cost sharing amounts in Table 1 of $24.79 and $58.71 are based on CMS data from 2012 with assumed 3% increases for each year between 2012 and 2021. These amounts are estimates; true costs will vary by state.** Medicare cost sharing will vary by beneficiary, but **states could use cost sharing payments for current QMB members to estimate potential cost sharing expenses for individuals who enroll in QMB after the state executes a Part A buy-in agreement.** States may also want to consider the potential for a "woodwork" effect (increasing new QMB enrollees) as a result of the state's advertisement of the new Part A buy-in agreement, if applicable.

[4] **Premium Penalty Avoidance.** Group payer states must pay late enrollment penalties that new QMB enrollees may owe in addition to the Part A base premium amount, but in buy-in states, these penalties are waived. **The $11.75 listed in Table 1 is an estimate based on 25% of members owing a $47 PMPM penalty. True amounts will vary by state.**

[5] **Medicare Covered Services.** States may experience large savings from Medicaid members transitioning into Medicare Part A, as Medicare will become the primary payer. **Medicare spent an average of $581 PMPM on Medicare Part A services in 2017 for individuals who were dually eligible for Medicare and Medicaid.** This $581 PMPM would be direct savings for states as these members costs shift from Medicaid to Medicare. **True costs for Medicare covered services will vary by state**.[6]

[6] **Medicare-Medicaid Integration Savings.** Members who have both Medicare Parts A and B may join Medicare-Medicaid integrated care plans, which may generate savings by offering supplemental benefits, such as dental, transportation, hearing or other benefits that otherwise would be covered by Medicaid. **The $15 listed in Table 1 is an estimate and will vary by state.**

[7] **Administrative Savings.** A Part A buy-in agreement may reduce administrative burden for state eligibility offices that no longer have to support beneficiaries bouncing back and forth between Social Security and state Medicaid eligibility offices as they attempt to meet application deadlines for QMB and conditional Part A coverage. **The $2 listed in Table 1 is an estimate and will vary by state.**

Step 2: Estimate the number of new people expected to enroll in Premium-Part A and QMB from each population group if your state implements a Part A buy-in agreement.

Next, estimate the number of people who may newly enroll in Premium-Part A and QMB, and multiply those estimates by the net savings PMPM calculated in Step 1. States considering a Part A buy-in agreement should contemplate the possibility of increased QMB enrollment and consequently increased Part A premium costs, that could come with executing a Part A buy-in agreement. (See **Appendix C** for data sources that states can use to identify individuals who may be eligible for but not enrolled in Premium-Part A and QMB.) In the example shown below in **Table 2**, approximately $2.3 million in annual savings is estimated for the 1,024 new members expected to enroll in Premium-Part A and QMB.

Table 2: Calculating Potential Annual Savings for Members New to Part A and QMB

	Medicaid and Medicare Part B	Medicaid but No Medicare Part B	No Medicaid but with Medicare Part B	No Medicaid, No Medicare Part B
Expected new population	500	500	12	12
Net savings PMPM	$78.56	$347.06	$(650.94)	$(652.94)
Annual savings (population x net savings x 12 months)	$471,360	$2,082,360	($93,735)	($94,023)
Total Annual Savings	**$2,365,961**			

Step 3: Estimate additional savings that the state could achieve by no longer needing to pay premium penalties for existing QMB enrollees with Premium-Part A.

Finally, estimate potential savings from the waiver of Part A premium penalties that the state is currently paying for existing QMB enrollees with Premium-Part A who owe a late enrollment penalty.

Table 3: Additional Savings from Avoidance of Premium Penalties for Existing QMB Enrollees

Number of Existing QMB Enrollees with Part A Premium Penalty	Premium Penalty Amount, 2021	Months of Penalty Owed in 2021*	Total Savings
650	$47.00/month	12	$366,600
500	$47.00/month	8	188,000
150	$47.00/month	4	$28,200
Total 2021 Savings for Premium Penalties			**$582,800**

*The length of a beneficiary's penalty period will depend on how long they were eligible for Part A but not enrolled. **States that are able to determine additional annual savings from the avoidance of premium penalties for existing QMB enrollees with Premium-Part A should consider those savings, as well**. Some states may not be able to complete this step, as they may not be able to accurately project the number of enrollees with penalties or the total potential savings from penalties.

Optional Step: Estimate the potential range of total costs and savings associated with executing a Part A buy-in agreement.

States are encouraged to repeat Steps 1, 2, and 3 to test different assumptions for expected costs, savings, and enrollment and determine a range for the potential financial impact of executing a Part A buy-in agreement. States may also want to consider longer-term impacts, such as changes in the population or potential lifetime savings achieved from shifting some service utilization costs from Medicaid to Medicare, which may generate higher savings as many individuals' costs become most expensive during the final years of their lives.

Appendix A. Potential New Costs for States that Execute a Part A Buy-in Agreement

In many cases, the new costs that a state incurs when executing a Part A buy-in agreement will be offset by the savings described in Appendix B. To analyze the potential new costs that may be incurred and compare them with potential savings, states should start by identifying the populations listed previously: (1) those with Medicaid and Medicare Part B; (2) those with Medicaid but no Part B; (3) those without Medicaid who have Part B; and (4) those without Medicaid or Part B. For each of those populations, states may encounter different types (and degrees) of potential new costs. Three categories of potential new costs – Part A premiums, Part B premiums, and coverage of Medicare cost sharing – and the population groups for which states could incur these new costs are described in the sections that follow. **Table A.1** summarizes the population groups for which each of these categories of new costs would be applicable.

Table A.1. Summary of Potential New Costs by Population Group of Individuals Eligible for Premium-Part A and QMB, But Not Yet Enrolled

Expected Costs	Medicaid and Medicare Part B	Medicaid but No Medicare Part B	No Medicaid but with Medicare Part B	No Medicaid, No Medicare Part B
Part A Premiums	X	X	X	X
Part B Premiums	-*	X	X	X
Part A Cost Sharing	X	X	X	X
Part B Cost Sharing	X	X	X	X

X = Additional costs expected
- = Additional costs not expected
* QMB enrollees that already have full Medicaid benefits and are enrolled in Part B are not likely to pose significant new costs to the state in most circumstances, as many states will already be covering the Part B premiums for these individuals (or the majority of these individuals) under their Part B buy-in agreements.

1. Part A Premiums

States pay Medicare Part A and Part B premiums for QMB enrollees through their Medicaid programs, and those payments are eligible for FMAP.[7] States without Part A buy-in agreements already pay the Part A premiums for existing QMB enrollees who owe such premiums via a group payer process. However, group payer states that are considering a Part A buy-in agreement should take into account the possibility of increased QMB enrollment, and consequently increased Part A premium costs. This potential additional cost of covering Part A premiums for new QMB enrollees applies to all of the populations listed in **Table A.1** above.

To accurately estimate the potential new costs of covering Part A premiums for new QMB enrollees, states may first want to estimate the percentage of potential new QMB enrollees for whom the state would have to pay the full Part A premium vs. the proportion for whom the state would pay a reduced monthly premium amount.[8] Nationally, CMS has estimated that in 2021, 89 percent of individuals enrolled in Premium-Part A owe a full premium ($471/month) and 11 percent owe a reduced premium ($259/month). Applying these percentages to the full and reduced monthly premium amounts for 2021 results in an expected average Part A premium cost of $447.68 per member per month (PMPM).

2. Part B Premiums

While Medicaid also covers Part B premiums for QMB enrollees ($148.50/month in 2021), new QMB enrollees who already have full Medicaid benefits and are enrolled in Part B are not likely to pose significant new costs to the state in most circumstances, as many states will already be covering the Part B premiums for these individuals (or the majority of these individuals) under their Part B buy-in agreements.[9]

The state would incur new costs for Part B premiums for individuals who are currently enrolled in Medicaid without Part B coverage if those individuals choose to enroll in Premium-Part A and QMB after the state executes a Part A buy-in agreement. It is worth noting, though, that those costs could very likely be offset by savings accrued in shifting primary payment for health care services to Medicare. (See **Appendix B** more information about expected savings.)

The population for which new costs for Part B premiums may be of most interest to states – because they pose potential new costs with less potential for offsetting savings[10] – is the group of individuals who are eligible for Premium-Part A and QMB, but who are not currently enrolled in Medicaid, regardless of whether they are currently enrolled in Part B. This population is likely small in all states but could be larger in states with full-benefit Medicaid eligibility criteria that are stricter than the criteria used to evaluate eligibility for QMB (for example, states in which full Medicaid benefits are only available to SSI recipients with incomes at or below 74 percent of the federal poverty level).

3. Medicare Cost Sharing

For QMB-eligible individuals without Medicaid, states may also incur new expenses for covering Medicare cost sharing if those individuals enroll in QMB once the state executes a Part A buy-in agreement. While Medicare cost sharing will also be a new expense for new QMB enrollees with Medicaid, the costs of covering Part A and B cost sharing (for which the state receives FMAP) could be offset by the savings attributable to shifting service utilization costs to Medicare (see **Appendix B** for information about potential savings).

Appendix B. Potential Savings for States that Execute a Part A Buy-in Agreement

While states may incur the new costs described in **Appendix A**, those costs may often be offset by a variety of savings that may be achieved through execution of a Part A buy-in agreement. Those potential savings are described in the sub-sections that follow.

4. Premium Penalty Avoidance

Both Part A buy-in and group payer states must cover the Part A premiums of QMB enrollees who qualify for Premium-Part A, but group payer states must also pay any late enrollment penalties that QMB enrollees may owe, as well.[11] In Part A buy-in states, those Part A premium penalties are waived, including penalties for QMB members enrolled prior to the state's execution of the Part A buy-in agreement. The savings that result from these penalty waivers can be substantial, depending on the number of QMB-eligible individuals who owe such a penalty and the duration of their penalty periods.

Example of a Part A Premium Penalty Calculation

Sam first became eligible for Premium-Part A in February of 2015 but did not enroll in Premium-Part A until July 2021. Sam enrolled into QMB at the same time, using the Premium-Part A conditional enrollment process.[12] Because Sam enrolled in Premium-Part A six years after he was first eligible, he incurred a 10 percent penalty for 12 years. In 2021, Sam owes a monthly Part A premium of $471/month, plus the 10 percent penalty ($47/month). As the Part A base premium increases in future years, the monthly penalty amount will also increase.

If Sam lives in a group payer state, the state will have to pay the additional $47/month in 2021 through the QMB program, along with the base premium of $471/month. The state will continue to pay the extra penalty amount for Sam's Part A coverage for the full 12 years that the penalty is owed, as long as Sam continues to remain eligible for QMB benefits.

If Sam lives in a Part A buy-in state, the state will only pay the base premium of $471/month for Sam's Part A coverage – the penalty amount will be waived by the federal government.

To estimate this additional savings on a state-specific basis, states can analyze their own data on the number of QMB enrollees for whom the state currently pays a Part A premium penalty and the average duration of those penalties. An example of how a state could estimate this savings is shown in **Table B.1** (next page), based on the two distinct populations (new enrollees and existing enrollees) for which states can avoid Part A late enrollment premium penalties.

Table B.1. Sample Calculation of State Savings from Avoidance of Late-Enrollment Premium Penalties

	New Members Who Qualify for Premium-Part A and Apply for QMB Benefits After the State Executes a Part A Buy-in Agreement	Members Already Enrolled in QMB and Premium-Part A with Existing Penalties
Average Penalty Amount PMPM	$47 PMPM in 2021	$47 PMPM in 2021
Percentage of Premium-Part A Members with a Penalty Each Year	25%	10%
Total PMPM Costs Avoided	$11.75 PMPM	$4.70 PMPM
Total Number of Members with Premium-Part A Buy-in	1,000	10,000
Total Annual Savings	**$141,000**	**$564,000**

5. Medicare-Covered Services

For beneficiaries who qualify for full Medicaid benefits, the state is already paying the full amounts for all Part A services for QMB-eligible individuals who need to pay a Part A premium. For beneficiaries with Medicaid who are eligible for Part B but not enrolled in Part B, the state is also covering the full cost of outpatient services, as well, and the costs of that coverage are not eligible for FMAP.[13]

Once a state executes a Part A buy-in agreement, that state can streamline enrollment into Premium-Part A for any Medicaid beneficiaries who already have Part B.[14] Individuals without Part B who are eligible for Premium-Part A and Part B will still be able to use the conditional enrollment process to enroll in Medicare.[15] Once these beneficiaries enroll in Medicare Part A, their inpatient hospital care, skilled nursing facility care, home health, hospice care, and other services will be covered by Medicare, generating potentially significant savings for the state. Medicare spent an average of $581 PMPM on Medicare Part A services in 2017 for individuals who were dually eligible for Medicare and Medicaid.[16] The actual costs savings that particular states can achieve as beneficiaries' health care services are covered under Medicare instead of Medicaid) depend on several factors, including:

a. **State Medicaid payment rates to providers for covered services.** In fee-for-service systems (and occasionally in managed care systems, as well), the costs of an individual beneficiary's service utilization under Medicaid coverage are higher in a state with higher provider payment rates than in a state with lower provider payment rates. Therefore, states with higher provider payment rates for services frequently utilized by dually eligible populations may derive greater savings from shifting the costs of covering those service to Medicare.
b. **Whether the state uses a fee-for-service or managed care delivery system.** States that cover dually eligible individuals under a fee-for-service system will incur direct costs for each service that a beneficiary utilizes, while states that cover these individuals under a managed care system typically pay capitated rates to managed care plans to provide coverage of Medicaid benefits. If those capitated rates do not vary based on actual service utilization, the potential savings that a managed care state would derive from a Part A buy-in agreement could be more dependent on the capitated rates paid to plans, rather than the actual service utilization of the beneficiaries.[17]
c. **Actual beneficiary utilization of services (and risk/case-mix of the applicable population).** In fee-for-service systems, the costs of covering beneficiaries under Medicaid (instead of Medicare) will depend on the number and types of services utilized by those beneficiaries. Similarly, beneficiaries' future service utilization could depend on their health and the prevalence of chronic disease within the populations involved.

Given the wide variation in these factors from state to state, state-specific data on beneficiary service utilization, fee-for-service provider payment rates, and/or managed care capitation rates are critical to

conducting accurate analyses on the potential savings of a Part A buy-in agreement attributable to shifting Medicaid coverage costs to Medicare.

In addition to considering the potential value of making Medicare the primary payer for beneficiaries' inpatient and outpatient services, states may also want to consider the potential value of having Medicare serve as the primary payer for those services over time. Because many individuals tend to need more inpatient and skilled nursing services as they get older, savings may accrue on an increasing basis, especially during the final years of an individual's life. Even in states where QMB-eligible individuals may not currently qualify for full Medicaid benefits, many of those QMB-eligible individuals may become eligible for full Medicaid benefits over time, ultimately triggering greater Medicaid costs later as they age.

That said, the most impactful immediate savings that states may generate by executing a Part A buy-in agreement and shifting primary payment responsibility to Medicare will come from shifting those costs for the population of Premium-Part A and QMB eligible individuals who currently have Medicaid coverage. Executing a Part A buy-in agreement would lead to a rapid shift in costs for those beneficiaries. Therefore, group payer states considering a Part A buy-in agreement may want to work with their actuaries to analyze the current service utilization costs for those enrollees, as well as their potential future costs over time, to estimate potential short and long-term savings.

6. Medicare-Medicaid Integration Savings

Dually eligible individuals who have both Medicare Part A and B coverage may enroll in integrated care plans, such as integrated Dual Special Needs Plans (D-SNPs) or Financial Alignment Initiative demonstration Medicare-Medicaid Plans (MMPs) – in states where such plans are offered. For states with integrated care plans, encouraging additional enrollment into those plans could help to support the complex needs of the state's dually eligible population and achieve savings, as MMPs and integrated D-SNPs are designed to streamline access to care for their members and reduce costs for Medicare and Medicaid. Additionally, some states have worked with D-SNPs to coordinate the supplemental benefits offered by the D-SNPs with the state's Medicaid benefits, particularly when states pay capitated rates to integrated D-SNPs that cover Medicaid benefits for their enrollees,[18] which may further states' ability to avoid costs that would otherwise fall on the Medicaid program.

7. Administrative Savings

A fourth opportunity for savings in executing a Part A buy-in agreement stems from the potential to reduce state administrative burden. Because Part A buy-in agreements enable states to streamline enrollment into Part A for anyone who already has Part B, those beneficiaries will no longer need to bounce back and forth between their local Social Security office and the state Medicaid eligibility office as they attempt to meet enrollment deadlines. Currently, Medicaid eligibility offices in group payer states must support these beneficiaries' attempts to enroll in conditional Part A and QMB. That support can often require significant staff time and expertise, and in some cases, other resources, as well – for example, when eligibility staff members print and share instructions for conditional enrollment processes or copies of a beneficiary's Medicaid/QMB eligibility information that they can take to Social Security to support their conditional enrollment application for Premium-Part A. The streamlined enrollment process not only makes it easier for beneficiaries to access the Medicare benefits for which they qualify; it can also be easier for state Medicaid staff to implement and oversee than complicated conditional enrollment processes.

Because the reduction in administrative burden would likely be greatest in shifting to a streamlined enrollment system to support Premium-Part A enrollment for those who already have Part B, it is expected that the potential for administrative savings to be greatest among states with a large portion of eligible beneficiaries in the populations (with or without Medicaid) that are already enrolled in Part B.

Summary of Potential Savings

Table B.2 summarizes the kinds of potential savings that could be expected for each population group of individuals who are eligible for Premium-Part A and QMB, but not enrolled when a group payer state executes a new Part A buy-in agreement.

Table B.2. Summary of Expected Savings by Population Group of Individuals Eligible for Premium-Part A and QMB, But Not Yet Enrolled

Expected Savings	Medicaid and Medicare Part B	Medicaid but no Medicare Part B	No Medicaid but with Medicare Part B	No Medicaid, No Medicare Part B
Premium penalty avoidance for new QMB enrollees	X	X	X	X
Medicare covered services	X	X	-	-
Medicare-Medicaid integration savings	X	X	X	X
Administrative savings	X	-	X	-

X = Savings are expected
- = Savings are not expected

Appendix C. Data Resources for Identifying QMB Enrollees and QMB-Eligible Individuals

States can use a variety of data sources to identify individuals who are eligible for or enrolled in the QMB program, including the following:

- **Medicare Modernization Act (MMA) Files** – States can use MMA files to identify individuals who are enrolled in Medicaid and Medicare Part B, but not Part A. By combining MMA file data with income and asset information in state Medicaid eligibility data, states can estimate how many individuals who are enrolled in Medicaid and Medicare Part B (but not Part A) might qualify for QMB benefits but are not yet enrolled in the QMB program. For more information on using MMA files, see:
    - MMA file overview and resources
    - ICRC tip sheet on using MMA files to identify dually eligible individuals
    - MMA file and field specifications are described in the CMS MAPD State User Guide

- **Medicare Beneficiary Summary Files (MBSF)** – States can use MBSF data to identify individuals who are enrolled in Medicare Part B, but not Part A, and are not enrolled in Medicaid. MBSF data show information about an individual's Medicare Parts A and B enrollment, as well as dual eligibility status, so a state can use this data to identify its Part B enrollees who have no Part A and no dual eligibility status (in other words, no Medicaid coverage). MBSF data do not provide information about income or assets, so states will not be able to tell from MBSF data alone whether these individuals might qualify for QMB benefits, but MBSF data can at least serve as a helpful starting place for understanding the size of this population as a whole. For more information on using MBSF data, see:
    - The CMS State Data Resource Center (SDRC) can help states access Medicare Beneficiary Summary File data.
    - The Research Data Assistance Center's data documentation for the MBSF Base file describes the Medicare enrollment and dual eligibility status information available in the MBSF.

[1] As of November 2021, the 14 states without Part A buy-in agreements are: Alabama, Arizona, California, Colorado, Illinois, Kansas, Kentucky, Missouri, Nebraska, New Jersey, New Mexico, South Carolina, Utah, and Virginia.

[2] For an introduction to Part A buy-in and the benefits for states of executing a Part A buy-in agreement, see the Centers for Medicare & Medicaid Services (CMS) Manual for State Payment of Medicare Premiums and related training tools. In particular, the Frequently Asked Questions describes the benefits of executing a Part A buy-in agreement.

[3] New costs can result from state coverage of monthly Medicare Part A premiums and cost sharing through the Qualified Medicare Beneficiary (QMB) program for individuals who qualify for, but are not currently enrolled in such coverage, and for whom a Part A buy-in agreement might make it easier to enroll.

[4] To enroll in QMB, an individual must have Medicare Part A. QMB-eligible individuals who choose not to enroll in Premium-Part A (for example, because they cannot afford the premium) cannot enroll in QMB until they enroll in Premium-Part A. These individuals can use a process known as conditional enrollment to align their Premium-Part A enrollment with their QMB coverage start date, but the conditional enrollment process can be difficult to navigate, especially in group payer states.

[5] Nationally, more than 99 percent of dually eligible individuals enrolled in Part-A buy-in in 2012 were in the QMB+ category (in other words, had both full Medicaid benefits and Medicare Parts A and B) per a report conducted for the CMS Medicare-Medicaid Coordination Office (MMCO), which is not publicly available. The information cited here was gathered from an email exchange with CMS on March 10, 2021.

[6] Medicare Payment Advisory Commission (MedPAC). "Data Book: Health Care Spending and the Medicare Program." July 2020. No longer available online.

[7] For more information about QMB benefits, see the CMS document entitled "Dually Eligible Individuals – Categories."

[8] Part A premiums are reduced for individuals who have at least 30 quarters of Medicare-covered employment (through their own work record, a spouse's work record, or an ex-spouse's work record in certain circumstances). In 2021, reduced Part A premiums are $259/month, while full premiums are $471/month (CY2021 Federal Register announcement).

[9] In 2021, all states have Part B buy-in agreements with CMS, and all states must cover the Part B premiums of individuals receiving cash assistance and those deemed to receive cash assistance, including individuals eligible for Medicaid by way of receipt of Supplemental Security Income (SSI) benefits, even if those individuals are not currently enrolled in the QMB program. For more information, see Chapter 1 of the Manual for State Payment of Medicare Premiums.

[10] States will not reap any savings from shifting to Medicare the costs of covering services under Medicaid for populations who are not currently covered under Medicaid. Other potential savings (described in Appendix B) could still apply to these populations, though.

[11] When an individual is eligible for Premium-Part A but does not enroll in Part A during their initial coverage election period for Medicare, that individual will owe a premium penalty if they choose to enroll in Premium-Part A at a later date. Part A premium penalties are 10 percent of the monthly Part A premium, and the duration of the penalty period is two times the number of years that the individual could have been enrolled in Part A but was not. For example, if an individual enrolls in Premium-Part A two years after their initial coverage election period, that individual would have to pay a Part A premium penalty for four years. When these individuals enroll in QMB coverage, the state becomes responsible for covering their Part A premiums. In group payer states, the state must pay the late-enrollment penalty amount along with the base premium.

[12] For information about the Premium-Part A conditional enrollment process, see HI 00801.140 in the Social Security Program Operations Manual System (POMS).

[13] See 42 CFR § 431.625(d)(3).

[14] For information about streamlined enrollment, see section 1.10 of Chapter 1 of the CMS Manual for State Payment of Medicare Premiums.

[15] For information about the Premium-Part A conditional enrollment process, see HI 00801.140 in the Social Security Program Operations Manual System (POMS).

[16] MedPAC. "Data Book: Health Care Spending and the Medicare Program." July 2020. No longer available online.

[17] It is also worth noting here that a "Medicaid only" beneficiary could shift from a managed care program to fee-for-service coverage (or vice versa) if they obtain dual eligible status via enrollment in Medicare through a state's Part A buy-in agreement.

[18] CMS HPMS Memorandum to D-SNPs and State Medicaid Agencies Contracting with D-SNPs, "Frequently Asked Questions on Coordinating Medicaid Benefits and Dual Eligible Special Needs Plans Supplemental Benefits," May 27, 2021.