State Health Insurance
Assistance Programs

Training Manual for Dual Eligible Programs

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TABLE OF CONTENTS

TABLE OF FIGURES

TABLE OF SPECIFIC INSERTS

Module I Overview

This module provides a general overview of Medicare and Medicaid, and programs designed to help low-income Medicare beneficiaries pay for their health care expenses. The focus of this training will be on the following programs:

- Qualified Medicare Beneficiary (QMB),
- Specified Low-Income Medicare Beneficiary (SLMB),
- Qualifying Individual (QI), and
- Qualified Disabled and Working Individual (QDWI).

The module begins with an overview of Medicare and Medicaid. It then explains the origins of QMB, SLMB, QI and QDWI, the purpose and goals of each program, the benefits of each program and how Medicare and Medicaid work together.

Learning Objectives

At the conclusion of this module, you will have learned:

- An overview of the Medicaid and Medicare programs.
- The origins of programs that help low-income beneficiaries pay for health care.
- The purpose of these programs.
- The benefits of each program.
- The interactions between Medicare and Medicaid.

Overview of Medicare

Medicare is the nation's largest health insurance program, covering 39 million individuals over the age of 65 and individuals with certain disabilities or permanent kidney failure. Congress established Medicare in 1965 under the Social Security Act in order to help reduce out-of-pocket costs for health care services among the elderly and disabled. Medicare is a federal program administered by the Health Care Financing Administration (HCFA).

In general, an individual is eligible for Medicare if he/she meets the following criteria:

- 65 years of age or older, or
- Younger than 65 with certain disabilities and have received disability benefits for at least 24 months, or
- Individuals with End Stage Renal Disease (ESRD) or with permanent kidney failure who need dialysis or transplant.

Medicare is composed of three parts:

Part A – Hospital Insurance

Medicare Part A Hospital Insurance provides coverage for services furnished by in-patient hospitals, skilled nursing facilities (SNF), home health agencies, and hospices.

Part B – Medical Insurance

Medicare Part B helps pay for doctors' services, in-patient and out-patient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, some preventive care and durable medical equipment (DME). Part B also pays for some home health care services not already covered under Medicare Part A. Participation in Medicare Part B is voluntary and requires payment of a monthly premium.

Under both Medicare Part A and Medicare Part B, there are substantial cost-sharing requirements (such as premiums, deductibles and coinsurance) that may leave some low-income beneficiaries at financial risk.

Medicare+Choice Program

Under the Balanced Budget Act (BBA) of 1997, Congress enacted major changes to the Medicare program. One of the most significant of these changes was the creation of the Medicare+Choice (M+C) program, which provides an expanded range of health care plan options for beneficiaries.

The M+C program includes the following options:

- **Managed Care Plans,** such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs). Managed care plans contract with groups of doctors, hospitals and other providers who have agreed to provide care to Medicare beneficiaries in exchange for a fixed amount of funds every month.

- **Medical Savings Accounts** (MSA) allow beneficiaries to enroll in a high-deductible health insurance plan (MSA plan) and open a tax-favored MSA. Medicare pays the premium for the high-deductible plan and contributes to the beneficiary's MSA. The beneficiary uses the funds in the MSA to pay for health care services before the plan deductible is met and for other services not covered by the MSA plan.

- **Private Fee-for-Service Plans** are health insurance plans that reimburse physicians and other providers on a traditional fee-for-service basis. Reimbursements for services are determined by the health plan, rather than the Medicare program. These plans are <u>not</u> the same as Medicare supplemental plans (or “Medigap” plans).

Beneficiaries must be covered by Medicare Parts A and B to participate in the M+C program and cannot have ESRD. Some participation rules for beneficiaries wishing to enroll in the M+C plans vary across plan types. In addition, M+C plans are not available in all parts of the country.

Overview of Medicaid

The Medicaid program was created in 1965 by Congress as Title XIX of the Social Security Act. Medicaid, or medical assistance, is administered by state Medicaid agencies within broad parameters established by federal regulations. Medicaid is a health care program designed primarily to help certain categories of low-income individuals with few financial resources. Approximately 30 million individuals received health benefits from state Medicaid programs in 1999. The federal government helps fund each state's Medicaid program. Within broad federal guidelines, each state establishes its own eligibility rules, benefit package and other program rules.

The following are key characteristics of the Medicaid program:

- Only certain categories of low-income individuals are eligible for Medicaid:
  - Low-income families, children and pregnant women
  - Individuals who are blind, aged or disabled
  - Older individuals with disabilities who require long-term care
  - Low-income elderly individuals
- Medicaid is a "needs-based" program. Applicants must prove that their income and financial resources are below certain defined levels to be eligible for benefits.
- Medicaid is jointly funded by the federal government and each state government.
- Payment for health care services is made by the state Medicaid program directly to health care providers.

- Each state's Medicaid program:

  - Establishes its own eligibility standards within broad federal guidelines
  - Determines the type, amount, duration and scope of services
  - Sets the rate of payment for services
  - Is responsible for administering its own program

However…

Federal law requires each state to provide a ***minimum*** benefits package, including hospital in-patient and out-patient services, physician services, skilled nursing home care, and laboratory and x-ray services.

- QMB, SLMB, QI and QDWI are all Medicaid programs.

Origins of QMB, SLMB, QI and QDWI Programs

In order to help protect low-income Medicare beneficiaries from the Medicare program's cost-sharing requirements, Congress has enacted several programs. Under the Medicare Catastrophic Coverage Act (MCCA) of 1988, Congress required each state's Medicaid program to "buy-in" to Medicare for low-income beneficiaries and persons with disabilities by paying for Medicare premiums, deductibles and coinsurance. Subsequent legislation was passed in order to cover individuals with slightly higher income levels. Individuals eligible for both Medicare and Medicaid coverage through any of the Medicare assistance programs are collectively known as the dual eligible population, or "dual eligibles".

There are several programs (often called "Buy-In Programs") that assist low-income beneficiaries with potentially high out-of-pocket health care costs:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Qualifying Individual (QI)
- Qualified Disabled and Working Individual (QDWI)

The programs are described below:

QMB: Qualified Medicare Beneficiary Program

- Created under the Medicare Catastrophic Coverage Act (MCCA) of 1988
- For Medicare beneficiaries with incomes at or below 100 percent of the federal poverty level who have limited financial resources
- Pays for Medicare beneficiaries' share of Medicare Part A (if applicable) and Medicare Part B premiums, deductibles and coinsurance
- Commonly referred to as "Quimby"

SLMB: Specified Low-Income Medicare Beneficiary

- Enacted under the Omnibus Budget Reconciliation Act (OBRA) of 1989
- Expanded the "Buy-In Program" by including Medicare beneficiaries with slightly higher income than those eligible under the QMB program
- For Medicare beneficiaries whose incomes are at least 100 percent, but less than 120 percent of the federal poverty level who have limited financial resources
- Pays for beneficiaries' share of Medicare Part B premiums
- Commonly referred to as "Slimby"

QIs: Qualifying Individual

- Created as a result of the Balanced Budget Act of 1997
- Authorized to operate from 1998 to 2002 under a five-year block grant to help pay Medicare Part B premiums for two additional groups of Medicare beneficiaries:

QI-1s (Qualifying Individual Group 1)

- for Medicare beneficiaries whose incomes are at least 120 percent, but less than 135 percent of the federal poverty level who have limited financial resources
- pays the Medicare Part B premiums for beneficiaries who are not otherwise eligible for Medicaid

QI-2s (Qualifying Individual Group 2)

- for Medicare beneficiaries whose incomes are at least 135 percent, but less than 175 percent of the federal poverty level who have limited financial resources
- pays a portion of Medicare Part B premiums for beneficiaries who are not otherwise eligible for Medicaid
- benefit amounts for QI-2 are based on increases in the Medicare Part B premium that are due to certain BBA provisions; however, benefit amounts for QI-2 will increase in subsequent years

Eligible beneficiaries receive assistance on a first-come, first-serve basis.

QDWI: Qualified Disabled and Working Individual

- Enacted as a result of the Omnibus Budget Reconciliation Act (OBRA) of 1989

- Aimed at disabled individuals:

  - whose earnings preclude entitlement to Medicare coverage but may purchase Medicare Part A
  - whose incomes do not exceed 200 percent of the federal poverty level
  - who have limited financial resources
  - who are not otherwise eligible for medical assistance
  - who lose their entitlement to free Medicare Part A benefits

- Pays for all or part of the Medicare Part A premium

Targeted at working disabled individuals **not** otherwise eligible for medical assistance.

Individuals with Full Medicaid Benefits

- Are eligible for benefits, such as long-term care and prescription drugs;
- May qualify for full Medicaid benefits due to spend-down (or the "medically needy" program);
- May also qualify for full Medicaid benefits due to limited income and financial resources; these groups are called "QMB Plus" or "SLMB Plus".

Medicaid with a "spend-down" (may also be referred to as the medically needy program) is for individuals whose income and resources are too high to qualify for Medicaid but have large medical expenses.

Chart I-1. Summary of Dual Eligible Programs

	Income Level	Benefit
QMB	Monthly income is at or below 100 percent of the federal poverty level	Covers Medicare Part A and Medicare Part B premiums, deductibles and coinsurance
SLMB	Monthly income is greater than 100 percent, but less than 120 percent of the federal poverty level	Covers Medicare Part B premiums
QI-1	Monthly income is at least 120 percent, but less than 135 percent of the federal poverty level	Covers Medicare Part B premiums
QI-2	Monthly income is at least 135 percent but less than 175 percent of the federal poverty level	Covers a portion of Medicare Part B premiums
QDWI	Monthly income is below 200 percent of the federal poverty level and individual has lost Medicare Part A benefits due to earnings	Covers Medicare Part A premium

Financial resources (or assets), such as interest earnings or savings in the bank, are also included in determining eligibility for these programs.

Description of Benefits

In 2000, **QMB** covers the following expenses:

Benefit	Expenses Covered
Medicare Monthly Premiums	
Medicare Part A	40+ quarters of employment $0 per month 30-39 quarters of employment $166 per month <30 quarters of employment $301 per month
Medicare Part B	$546.00 a year, or $45.50 per month
Medicare Deductibles	
Medicare Part A	$776.00 per benefit period*
Medicare Part B	$100.00 per year
Medicare Part A Coinsurance	
Hospital	
1 - 60 days	$0
61 - 90 days	$194.00
91 - 150 days	$388.00
Skilled Nursing Facility	
1 - 20 day	$0
21 - 100 day	$97.00
Medicare Part B Coinsurance	20 percent of the allowed (usual and customary) charge for covered services

*A benefit period begins when an individual is admitted to the hospital and ends when that individual has been released from the hospital or skilled nursing facility (SNF) for 60 consecutive days, or when he/she has remained in a SNF but has not received daily skilled care.

In 2000, **SLMB** covers the following expenses:

Benefit	Expenses Covered
Medicare Monthly Premiums	
Medicare Part B premium	$546.00 a year, or $45.50 per month

In 2000, **QI** covers the following expenses:

Benefit	Expenses Covered
QI-1 Medicare Monthly Premiums	
Medicare Part B premium	$546.00 a year, or $45.50 per month
QI-2 Medicare Monthly Premiums	
A portion of the Medicare Part B premium	$34.44 a year, or $2.87 per month

In 2000, **QDWI** covers the following expenses:

Benefit	Expenses Covered
Medicare Monthly Premiums	
Medicare Part A	40+ quarters of employment $0 per month 30-39 quarters of employment $166 per month <30 quarters of employment $301 per month

How Medicare and Medicaid Work Together

Are there similarities between Medicare and Medicaid?

Absolutely. Both are part of the Social Security Act and both are health care-related programs.

The two programs however have significant differences. **Medicare** is a federal program that provides health insurance to almost all individuals who are at least 65 years old, certain disabled individuals and individuals with ESRD, regardless of income.

Medicaid is a joint federal and state government program that assists certain categories of low-income individuals of any age by providing health insurance coverage. Medicaid is not automatic for Medicare beneficiaries, because one must apply and meet eligibility requirements.

Each state establishes its own eligibility criteria and determines the scope of benefits covered within broad federal guidelines. If eligible for both Medicare and Medicaid, individuals are known as "dual eligibles" and receive the benefits of both programs.

Recipients who are fully eligible for Medicaid receive coverage for some health services not generally covered by Medicare (e.g., prescription drugs).

What is the most important point to remember?

For some Medicare beneficiaries, Medicaid can help pay for some, but not all, health costs not covered by Medicare.

While Medicare provides broad coverage of health care services, gaps in Medicare coverage may leave beneficiaries financially liable for high out-of-pocket costs. Some of the potential gaps include:

- Medicare Part A hospital deductible and coinsurance
- Cost of days in the hospital, if Medicare coverage runs out
- Annual Medicare Part B deductible
- 20 percent of Medicare-approved amount for doctors' services
- Non-Medicare covered services, such as eyeglasses, hearing aids, dental care and prescription drugs

If a person's income and financial resources are limited enough to qualify, Medicaid can cover some or all of the costs of the above items.

Medicaid is important in protecting low-income **Medicare** beneficiaries from the consequences of high out-of-pocket health costs.

Medicaid offers a more comprehensive benefit package than Medicare.

Chart I-2: Comparison of Medicare and Medicaid

	Medicare	Medicaid
Coverage	Health insurance for individuals aged 65 or older; any income level	Assistance for certain categories of individuals with low incomes
Eligibility	Based on Social Security and age or disability	Based generally on financial need
Administration	Federal	State
Funding	Federal	Federal-state funding
Uniformity	Uniform in all states	Varies by state
Benefits	Limited; hospital and physician services, and limited preventive and long-term care	More comprehensive; hospital and physician services, long-term care, dental, prescriptions and transportation
Cost-Sharing	Participants pay premiums, deductibles and coinsurance	Medicaid's payment to providers is considered payment in full

Summary of Module

In this module you have learned:

- When and why the "Buy-In Programs" were initiated.
- The purpose, goals and description of the four programs.
- The specific benefits of each of the programs.
- A brief history of Medicaid.
- Differences between Medicare and Medicaid and how they work together.

Technical Appendix

Range of Dual Eligible Categories

The following describes the various categories of individuals who, collectively, are known as dual eligibles. Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

Qualified Medicare Beneficiaries without Other Medicaid (QMB Only)

- Entitled to Medicare Part A
- Monthly income equal to 100 percent of the federal poverty level or less
- Financial resources that do not exceed twice the limit for Supplemental Security Income (SSI) eligibility
- Not eligible for full Medicaid benefits
- Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers

QMBs with Full Medicaid (QMB Plus)

- Entitled to Medicare Part A
- Monthly income equal to 100 percent of the federal poverty level or less
- Financial resources that do not exceed twice the limit for SSI eligibility
- Eligible for full Medicaid benefits
- Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits.

Specified Low-Income Medicare Beneficiaries without Other Medicaid (SLMB Only)

- Entitled to Medicare Part A
- Monthly income greater than 100 percent of the federal poverty level, but less than 120 percent of the federal poverty level
- Financial resources that do not exceed twice the limit for SSI eligibility
- Not eligible for full Medicaid benefits
- Medicaid pays their Medicare Part B premiums only

SLMBs with full Medicaid (SLMB Plus)

- Entitled to Medicare Part A
- Monthly income greater than 100 percent of the federal poverty level, but less than 120 percent of the federal poverty level
- Resources that do not exceed twice the limit for SSI eligibility
- Eligible for full Medicaid benefits
- Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits.

Qualified Disabled and Working Individual (QDWI)

- Individuals who lost their Medicare Part A benefits due to their return to work
- Eligible to purchase Medicare Part A benefits
- Monthly income 200 percent of the federal poverty level or less
- Financial resources that do not exceed twice the limit for SSI eligibility
- Not otherwise eligible for Medicaid
- Medicaid pays the Medicare Part A premiums only

Qualifying Individual (1) (QI-1)

- Program effective 1/1/98 - 12/31/02
- There is an annual cap on the amount of money available, which may limit the number of individuals in the group
- Entitled to Medicare Part A, have monthly income of at least 120 percent of the federal poverty level, but less than 135 percent of the federal poverty level
- Financial resources that do not exceed twice the limit for SSI eligibility
- Not otherwise eligible for Medicaid
- Medicaid pays their Medicare Part B premiums only

Qualifying Individual (2) (QI-2)

- Program is effective 1/1/98 - 12/31/02
- There is an annual cap on the amount of money available, which may limit the number of individuals in the group.
- These individuals are entitled to Medicare Part A, have monthly income of at least 135 percent of the federal poverty level, but less than 175 percent of the federal poverty level
- Financial resources that do not exceed twice the limit for SSI eligibility
- Not otherwise eligible for Medicaid
- Medicaid pays only a portion of their Medicare Part B premiums

Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1, or QI-2)

- Entitled to Medicare Part A and/or Part B
- Eligible for full Medicaid benefits
- Not eligible for Medicaid as a QMB, SLMB, QDWI, QI-1 or QI-2
- These individuals need to spend down to qualify for Medicaid or fall into a Medicaid eligibility poverty group that exceeds the limits listed above
- Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but Medicaid will only pay for services also covered by Medicare, if the Medicaid payment rate is higher than the amount paid by Medicare and, within this limit, will only pay to the extent necessary to pay the beneficiary's Medicare cost-sharing liability.
- Payment by Medicaid of Medicare Part B premiums is a state option; however, states may not receive federal financial participation for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B, had they been enrolled

While most states use QMB, SLMB, QI and QDWI to identify these programs, some states may use different names for these programs. For example, in New Hampshire, the QI-1 program is called SLMB135 and the QI-2 program is called SLMB175.

Module II Overview

This module is designed to educate counselors on eligibility criteria for potential dual eligible beneficiaries (those who are eligible for both Medicare and Medicaid). Each section of the module is intended to present and reinforce the different components of the eligibility criteria.

Learning Objectives

At the conclusion of this module, you will be able to:

- Describe the eligibility criteria for QMB, SLMB, QI and QDWI programs for potential dual eligible beneficiaries.
- Provide examples of items that are counted as financial resources.
- Use screening tools to identify which program(s) would best meet the needs of a given beneficiary.

Eligibility Criteria: QMB, SLMB, QI and QDWI Programs

The QMB, SLMB, QI and QDWI programs have income and financial resource limits that determine eligibility. In order to determine if an individual qualifies for these programs, follow the steps outlined below:

Step 1: Determine Medicare Part A Eligibility

Determine whether the potential dual eligible beneficiary currently has, or is eligible for, Medicare Part A (Hospital Insurance).

Individuals may be eligible for Medicare Part A if he/she meets the following criteria:

- 65 years of age or older, or
- Younger than 65 with certain disabilities and have received disability benefits for at least 24 months, or
- Individuals with End Stage Renal Disease (ESRD) or with permanent kidney failure who need dialysis or transplant, and
- A legal resident of the United States for at least five years.

If you are unsure about an individual's status, check their Medicare card or call your local Social Security Office. You may also call Social Security's toll-free number at 1-800-772-1213.

Step 2: Estimate Monthly Income

Check whether or not the individual's monthly income is below certain limits, which are linked to the federal poverty level guidelines.

> As a counselor, you are only estimating the individual's income level. The state will determine if the individual meets the required monthly income limit.

Income includes funds received on a monthly basis from Social Security, wages, pensions or veteran's benefits.

> Eligibility for program benefits is based on an individual's gross income minus certain income exclusions, such as the first $20 of any monthly income.

The income limits for 2000, including the $20 monthly income disregard, are presented below.

Table II-1. 2000 Monthly Income Limits

Monthly Income Limits		Program Name
Individuals	Couples	
$716*	$958*	QMB
$855	$1,145	SLMB
$960	$1,286	QI-1
$1,238	$1,661	QI-2
$1,412	$1,895	QDWI

*Alaska and Hawaii have slightly higher income limits (see the following page). Other states may have more liberal methods in determining income eligibility (see pg. II-10).

Monthly Income Limits for Alaska and Hawaii

Table II-2. 2000 Monthly Income Limits for Alaska

Monthly Income Limits		Program Name
Individuals	Couples	
$890	$1,192	**QMB**
$1,063	$1,426	**SLMB**
$1,194	$1,602	**QI-1**
$1,542	$2,071	**QI-2**
$1,759	$2,364	**QDWI**

Table II-3. 2000 Monthly Income Limits for Hawaii

Monthly Income Limits		Program Name
Individuals	Couples	
$820	$1,098	**QMB**
$979	$1,313	**SLMB**
$1,099	$1,475	**QI-1**
$1,419	$1,906	**QI-2**
$1,619	$2,175	**QDWI**

When determining monthly income limits with a potential dual eligible beneficiary, counselors should estimate an individual's **gross** income, that is, all possible sources of income. Potential eligibles tend to provide their **net** income. For example, they often provide the amount of their Social Security check, which generally includes a deduction for the Medicare Part B premium.

Gross income means all income derived from whatever source, including funds from Social Security, wages or pensions. It is the income before deductions, such as Medicare Part B premiums or taxes, are taken out.

Net income means income received by the beneficiary after deductions, such as Medicare Part B premiums or taxes, have been taken out.

Eligibility for QMB, SLMB, QI and QDWI is based on an individual's gross income minus certain income exclusions. Certain services and payments are excluded when calculating income to determine eligibility for dual eligible programs, such as the first $20 of any monthly income or the value of the food stamp benefit.

Potential eligibles tend to provide their net income (e.g., the amount of their Social Security check, which generally includes a deduction for the Medicare Part B premium). Make sure you probe for an individual's gross income.

Income Exclusions

Items and benefits that are not counted when calculating gross income for QMB, SLMB, QI and QDWI program eligibility are shown below:

- First $20 of any monthly income
- First $65 of monthly earned income and one-half of the remaining monthly earned income received
- Value of food stamp benefits
- Income tax refunds
- Weatherization assistance
- State or local government assistance based on need
- Small amounts of income received inconsistently
- Food or other in-kind assistance provided by private non-profit agencies, based on need
- Cash or in-kind assistance that is loaned and must be repaid
- Money someone else spends directly to pay expenses for items other than food, clothing or shelter (e.g., telephone bill)
- Value of food and shelter received free of charge while living in the household of another

The following is an example of the income exclusion:

For example:

An individual receives $590 dollars in his/her Social Security check (this figure excludes their contribution for Medicare Part B premiums) and works part-time receiving approximately $150 per month.

To estimate the individual monthly income, a counselor first determines the person's gross income by adding $45.50 (the Medicare Part B premium for 2000) to their social security and employment income.

$590 + $150.00 + $45.50 = **$785.50**

The counselor would then subtract $20 (the first $20 of any monthly income).

$785.50 - $20.00 = **$765.50**

Another exclusion is the first $65 of monthly earned income ($150.00 - $65.00 = **$85.00**) and half of the remaining earned income ($85.00 / 2 = **$42.50**).

The estimated income with exclusions is:

$765.50 - $65.00 - $42.50 = **$658.00**

In determining income eligibility for individuals, some states may be less restrictive. The following states have more liberal methods for determining income eligibility:

- Arizona
- California
- Connecticut
- Florida
- Idaho
- Kansas
- Massachusetts
- Minnesota
- Mississippi
- North Dakota
- South Carolina
- Wisconsin
- Wyoming

Special Income Disregard for Cost of Living Adjustments (COLA)

There is a special disregard for Cost-of-Living Adjustments (COLA) added to Social Security benefits in January of each year. The new COLA, effective in January, is not counted when determining the eligibility for QMB, SLMB, QI and QDWI for the months of January, February and March. This amount is counted starting April 1, the effective date of new income limits for dual eligible programs.

Example:

On December 3, a person received $690 in social security benefits and, on January 3, $699 in Social Security benefits. The $9 COLA received in January will not be counted as additional income when determining eligibility for QMB, SLMB, QI and QDWI for January, February and March. Effective April 1st, the COLA of $9 is counted as additional income and $699 is used to determine if the person is eligible for program benefits.

Changes in the Federal Poverty Level

In February or March each year, the federal government releases the new federal poverty levels. These new federal poverty levels change the income eligibility limits for a range of public benefits, including the QMB, SLMB, QI and QDWI programs.

The effective date of the new income limits (based on the federal poverty level) for QMB, SLMB, QI and QDWI program benefits is April 1st. On April 1st, potential dual eligible beneficiaries who did not qualify for dual eligible programs last year due to income slightly above the federal poverty level may be eligible this year for program benefits.

Potential dual eligible beneficiaries who did not qualify this year because of their income should be alerted that they may be eligible next year, when changes in the income limits become effective on April 1st.

Step 3: Estimate Financial Resources

Assist in estimating an individual's financial resources, or assets.

To be eligible for QMB, SLMB, QI or QDWI, financial resources must be below **$4,000** for an individual or **$6,000** for a couple.

Financial resources or assets include:

- Cash
- Bank accounts, such as savings and checking accounts
- Stocks, bonds, annuities and CDs (Certificates of Deposit)
- Real and personal property (other than home and one automobile)
- Trusts
- Life insurance if face value is greater than $1,500. Only the cash surrender value (the amount of cash a person may obtain by voluntarily surrendering a life insurance policy) of such a policy is counted
- Other items that may be converted into cash and used for food, clothing or shelter:

_____

_____

Trainers: Please check the financial resources or assets that are applicable to your state.

Some states may also be less restrictive in determining eligibility based on financial resources. The following states have more liberal methods for determining eligibility based on financial resources:

- Alabama
- Arizona
- California
- Florida
- Idaho
- Kansas
- Massachusetts
- Minnesota
- Mississippi
- Montana
- New York

Resource Exclusions

Financial resources that are excluded when determining eligibility are presented below:

- Full value of the home a person lives in and the land it is on
- One automobile
- Household and personal property, unless of unusual value
- One wedding ring and one engagement ring
- Burial spaces for a person and immediate family members
- Burial funds for an individual and spouse, valued up to $1,500 for each person (the value of the burial funds must be offset against the face value of any excluded life insurance policies--see next bullet)
- Cash surrender value of life insurance policies with a combined face value of $1,500 or less (exclusive of term and burial insurance policies)
- A retroactive SSI or Social Security check is excluded for six months after receipt

Spend-Down and Dual Eligible Programs

QMB, SLMB, QI and QDWI programs do not have a "spend-down" process. "Spend-down" is used in most states to determine eligibility for full Medicaid benefits. Eligibility for QMB, SLMB, QI and QDWI is purely based on whether individuals pass or fail the income and financial resource eligibility criteria described earlier.

QMB, SLMB, QI and QDWI programs do not have a "spend-down" process.

Step 4: (Optional) Contact Your Local Social Services Agency

Contact your local social services (or other) state agency [*State SHIPs should insert the appropriate name of their state agency*] office for additional information, if necessary. The telephone number of your local social services agency office is located in the government section of the telephone book under one or more of the following:

- Medicaid
- Social Services
- Medical Assistance
- Public Assistance
- Human Services or
- Community Services

You may also call **1-800-638-6833** to find the local social services agency office in your state. For your state's social services (or other) agency [*State SHIPs should insert the appropriate name of their state agency*] office, you may also visit http://www.medicare.gov on the Internet.

Effective Date of Coverage for Dual Eligible Programs

QMB: Qualified Medicare Beneficiary

An individual potentially eligible for QMB may become eligible for benefits on the first day of the month following the month in which the social services (or other) state agency office has received all the required information and has made an eligibility determination. The process for determining eligibility should take no longer than 45 days.

For both QMB and SLMB, it may take about eight to twelve weeks from the approval date before the Medicare Part B premium is no longer deducted from a beneficiary's Social Security check and premiums in the interim are refunded.

QMB benefits are not retroactive. Benefits become effective at the beginning of the first calendar month after the month when eligibility was determined.

For example:

January	February	March	April	May	June
Month of Application		Month of Decision	Month of benefit coverage		

SLMB: Specified Low-Income Medicare Beneficiary

Unlike the QMB program, an individual potentially eligible for SLMB may be entitled to benefits as of the month of approval, or benefits may be retroactive for up to three months.

Eligibility is determined by general Medicaid rules. The social services (or other) agency looks back three months to determine if an individual's income and resources would have made them eligible in these months. If social services agency determines that the individual was eligible three months ago, then the SLMB benefits would be retroactive for three months. If the individual does not qualify for SLMB until the time of application, then the benefits would not be retroactive.

SLMB benefits are retroactive for up to three months prior to the month of application, if the individual met income and resource criteria during that time.

For example:

July	August	September	October	November	December
Earliest Month of Coverage			Month of Approval		

Application is made September 17 and approved October 11. Eligibility begins October 1, and the benefit is retroactive to July 1.

The Medicare Part B premium was already withheld from the October Social Security check and will be refunded. For the months of July, August and September, the benefit will be received in the form of a refund from Social Security. Beginning November 1 or soon thereafter the Medicare Part B premium will no longer be withheld from the Social Security check.

QI: Qualifying Individual

Like the SLMB program, an individual potentially eligible for the QI programs may be entitled to benefits as of the month of approval or up to three months prior to the month of application within the same calendar year.

Eligibility is determined by general Medicaid rules. The social services (or other) agency looks back three months to determine if an individual's income and resources would have made them eligible in these months. If social services (or other) agency determines that the individual was eligible three months ago, then the QI benefits would be retroactive for three months. If the individual does not qualify for QI until the time of application, then the benefits would not be retroactive.

QI benefits are retroactive for up to three months prior to the month of application, if the individual met income and financial resource requirements during that time.

For example:

July	August	September	October	November	December
Earliest Month of Coverage			Month of Application		

Eligibility Screening Tools

Screening tools have been developed by many organizations to help determine if individuals are eligible for programs that pay for some or all of Medicare's cost-sharing requirements.

The following screening tool developed by HCFA has been included as an example. If your local SHIP office uses another screening tool, this is also provided. The HCFA screening tool provides step-by-step instructions on how to determine eligibility:

1. Estimates of financial resources or assets, such as cash, checking and savings accounts, stocks and bonds.

2. Calculation of countable (e.g., monthly earnings and retirement or disability benefits) monthly income to determine if income is at or below the specified income limits for QMB, SLMB, QI and QDWI.

3. Enrollment and/or eligibility for Medicare Part A.

4. Potential benefit section which approximates if an individual is eligible for dual eligible programs.

HCFA Screening Tool

Intermediary's Screening Tool for
Savings Programs for Medicare Beneficiaries

Complete the following information to find out if an individual may qualify for programs that help pay Medicare expenses. Keep in mind that this is just a screening tool. Each state has specific income and resource criteria for enrollment. Prior to beginning the screening, please inform the individual of the following: *"This is a preliminary, **voluntary** screening to see if you might be eligible for programs that help pay Medicare expenses. It is not an application for these programs. The information you provide will assist us in determining if you may be eligible for these programs. We will **not** be maintaining a permanent record of the financial data that you provide, nor will we use the data in any other way."*

Step 1 **Resource Section**							
Indicate the value of the property that belongs to applicant and/or spouse. If jointly owned, place under "joint." Do not include up to $1,500 if it has been set aside for burial expense.		**Applicant**		**Spouse**		**Joint**	
1	Checking Account	1a		1b		1c	
2	Savings Account	2a		2b		2c	
3	Certificate(s) of Deposit	3a		3b		3c	
4	Stocks or Bonds	4a		4b		4c	
5	Money in Trust Funds	5a		5b		5c	
6	A Second Car Value _____ – (Minus) Amount Owed _____ =	6a		6b		6c	
7	A Second Home Value _____ – (Minus) Amount Owed_____ =	7a		7b		7c	
8	Other Real Property (land, buildings, etc.)	8a		8b		8c	
9	Add all resources (1 through 8).	9a		9b		9c	
10	Resources for Applicant. Add amount in 9a_____ + amount in 9c_____ =	10a					
11	Resources for Spouse Amount in 9b_____ =			11b			
12	Resources for Couple Add amount in 9a _____ + 9b_____ + 9c_____ =					12c	

If total resources are more than $4000 for single applicant or $6000 for a couple, it is not likely that the individual qualifies for one of the dual eligible programs.

Step 2 Income Section

Indicate the monthly amounts of income that applicant and/or spouse receives.		Applicant		Spouse	
1.	Total Monthly Gross Earnings	1a		1b	
2.	Add amount in 1a_____+ amount in 1b_____=	2a			
3.	Subtract $65.00 from amount in 2a_____=	3a			
4.	Total Countable Earned Income Divide amount in box 3a _____ by 2 (two) =	4a			
5.	Social Security Check	5a		5b	
6.	VA Benefits	6a		6b	
7.	Interest from Bank Accounts or CDs	7a		7b	
8.	Retirement or Disability Benefits	8a		8b	
9.	Other Unearned Income	9a		9b	
10.	Total Unearned Income Applicant Add amount in 5a through 9a	10a			
11.	Total Unearned Income Spouse Add amount in 5b through 9b			11b	
12.	Total Unearned Income Add amount in 10a_____+ amount in 11b_____=	12a			
13.	Total Countable Income Add amount in 4a_____+ amount in 12a_____=	13a		13b	

Step 3 Medicare Section

❒	Is applicant enrolled in Medicare Part A?	❒Yes	❒No
❒	Is spouse enrolled in Medicare Part A?	❒Yes	❒No

The Individual must be enrolled in Medicare Part A to qualify for the dual eligible programs. If the individual is not enrolled in Medicare Part A, call the Social Security Administration toll free at 1-800-772-1213 to see if he/she is eligible for enrollment in Medicare Part A. If the individual is not enrolled in Medicare Part A because of the cost of the Medicare Part A premium, and his/her income is low enough (at or below 100% of the Federal Poverty Level plus $20 standard disregard --$716 or less for an individual, or $958 or less for a couple), he/she may be eligible for the Qualified Medicare Beneficiary Program (QMB) that may pay the Medicare Part A premium for the individual.

Step 4	**Potential Benefit Section (2000 Income Limits)** The following are approximations for eligibility. Each state has specific limits. If the individual's income is slightly above any of the following limits, especially if the individual resides in Alaska and Hawaii where the limits are higher then those listed below, it is advisable that the individual still contact the state to see if he/she is eligible. The income limits are increased slightly in April of each year.
❒	If monthly income for an individual is $716 or less, or $958 or less for a couple (below 100% of the Federal Poverty Level plus the $20 standard disregard), the individual is potentially eligible for the Qualified Medicare Beneficiary program (QMB) that may pay Medicare premiums, deductibles, and coinsurance charges for the individual. Savings for most people are more than $546 a year. The individual may also receive additional benefits if he/she qualifies for full Medicaid.
❒	If monthly income for an individual is greater then $716 but less than $855, or greater than $958 but less than $1,145 for a couple (greater than 100% of the Federal Poverty Level but less than 120% Federal Poverty Level plus the standard $20 disregard), the individual is potentially eligible for the Specified Low Income Medicare Beneficiary program (SLMB) that may pay the Medicare Part B premium for the individual. In 2000, the premium is $45.50 each month, or $546 a year. The individual may also receive additional benefits if they qualify for full Medicaid.
❒	If the monthly income for an individual is greater then $855 but less than $960, or greater than $1,145 or less than $1,286 for a couple (greater than 120% of the Federal Poverty Level but less than 135% Federal Poverty Level plus the standard $20 disregard), the individual is potentially eligible for the Qualifying Individual (QI-1) program that may pay the Medicare Part B premium for the individual. In 2000, the premium is $45.50 each month, or $546 a year. There is a state specific limit to the number of individuals who can be enrolled in this program, and the individual cannot have any other form of Medicaid.
❒	If the monthly income for an individual is greater then $960 but less than $1,238, or greater than $1,286 or less than $1,661 for a couple (greater than 135% of the Federal Poverty Level and but less than 175% Federal Poverty Level plus the standard $20 disregard), the individual is potentially eligible for the Qualifying Individual (QI-2) program that may pay a portion of the Medicare Part B premium for the individual. In 2000, the reimbursement is $34.44 a year for an individual. There is a state specific limit to the number of individuals who can be enrolled in this program, and the individual cannot have any other form of Medicaid.
❒	If the individual is disabled, and lost their Medicare Part A benefits due to their return to work, he/she may be eligible for the Qualified Disabled and Working Individuals (QDWIs) program if his/her income is $1,412 or less, or $1,895 or less for a couple (below 200% of the Federal Poverty Level plus the standard $20 disregard). The individual cannot have any other form of Medicaid.

Placeholder for Other Screening Tool

Trainers: If applicable, please insert your office's screening tool.

Summary of Module

In this chapter, you learned:

- The eligibility criteria for dual eligible programs.
- The importance of income and financial resources in determining eligibility criteria.
- Use of screening tools to determine eligibility.

Module III Overview

This module covers the various components of the enrollment process for QMB, SLMB, QI and QDWI. Knowledge of the enrollment process is critical for counselors advising potential eligible beneficiaries on how to apply for these programs.

Learning Objectives

Upon completion of this module, participants will be familiar with:

- The enrollment process for QMB, SLMB, QI and QDWI.
- The documents needed for enrollment application.
- The application form.

Enrollment Process

For potential beneficiaries of dual eligible programs, the application process may discourage them from applying for benefits. In some states, applicants are required to complete a full Medicaid application, which may be complicated and lengthy. In addition, applicants may need the assistance of an eligibility worker to complete the application. The process for verifying an applicant's reported financial resources is often time-consuming for both the applicant and the eligibility worker. Furthermore, some states require in-person interviews, which creates application barriers for homebound beneficiaries and those concerned with the welfare stigma.

States have recognized the problems associated with the application and enrollment process. Many states have introduced new and improved processes to increase the ease and convenience of the application process.

This section provides general guidelines regarding the application process and your role in assisting potential eligible beneficiaries to apply for program benefits.

Applying for QMB, SLMB, QI and QDWI Programs

Where to Obtain and Complete an Application

Where to Obtain an Application

Generally, potential eligible beneficiaries may obtain an application for program benefits from the social services (or other) state agency *[State SHIPs should insert the appropriate name of their state agency]* or other sites (see page III-7). When the potential eligible contacts the appropriate agency, he/she should ask about the programs that cover Medicare out-of-pocket costs, such as premiums, deductibles and coinsurance.

In some states, dual eligible programs are known by different names. You should provide the potential eligible with written materials (such as a fact sheet or brochure) describing these programs and the name of the programs: QMB, SLMB, QI and QDWI. This will help the potential eligible beneficiary and the eligibility worker in obtaining the correct application form.

While most states use QMB, SLMB, QI and QDWI to identify these programs, some states may use different names for these programs. For example, in New Hampshire, the QI-1 program is called SLMB135 and the QI-2 program is called SLMB175.

Where to Complete an Application

Many states have identified alternative sites where potentially eligible beneficiaries can obtain and/or complete their application for program benefits. Alternative enrollment sites lessen the resistance of some potential eligibles to visit their local social services agency due to welfare stigma.

At some of these enrollment sites, volunteers or other providers assist in completing the application. However, at some sites, eligibility workers have been assigned from their regular office, which allows them to make eligibility determinations at that site.

The following table lists possible sites (including the social service agency) where your state may allow applications to be obtained and/or completed.

Table III-1. Locations Where Applications Obtained or Completed

	Applications May Be Obtained	Applications May Be Completed
Local social service agency		
Hospitals		
Rural health clinics		
Federally-qualified health centers		
Homeless shelters		
Other government offices		
Courthouses		
Nursing homes		
Senior centers		
Senior housing centers		
Area Agencies on Aging (AAA)		
Tribal Organizations		
Libraries		
SHIPs		
Other _____		

In the Technical Appendix of this module, the table presents sites (other than the social service agency) where states accept applications. This information is from a survey conducted by the American Public Human Services Association in 1999.

Trainer: In the table above, check at which sites your state permits applications to be obtained and/or completed.

How to Submit an Application

Some states require potential eligibles to come in for in-person interviews for program benefits at the local social services agency office. Other states, however, do not require applicants to appear in person during the application process. Some states accept applications in the following ways:

Table III-2. Ways to Submit Applications in *[State]*

Method	Yes	No	Comments
In-person			
By mail			
By telephone with mail follow-up			
By fax			
Electronic submission from remote site			

Trainer: In the table above, check which methods are allowed in your state and provide some detail on the way applications can be submitted.

Example:

Method	Yes	No	Comments
In-person	**X**		State requires an individual to apply in-person with a state eligibility worker. However, the application form may be completed before the interview and eligibility workers have been stationed in locations other than the social service agency.
By mail		**X**	
By telephone with mail follow-up		**X**	
By fax		**X**	
Electronic submission from remote site		**X**	

File a Written Application

You should encourage potential eligible beneficiaries to file a formal written application for benefits. Potential eligible beneficiaries are entitled to file an application, even if the eligibility worker believes that the applicant may be ineligible. Eligibility can only be determined after verifying all the information in the application.

You should be familiar with the application form your state uses for dual eligible programs. This will enable you to answer questions that potential eligible beneficiaries may have when completing the application.

In the Technical Appendix, there is an example of a model application developed by the Health Care Financing Administration (HCFA). This application is an example of the types of information typically asked of potential eligible beneficiaries.

Homebound Beneficiaries:

For potential eligible beneficiaries who are homebound, most states allow telephone interviews, applications by mails, home visits by eligibility workers, or assignment of an authorized representative to file on behalf of the homebound beneficiary. [*SHIP offices should insert specifics for your state*].

Non-English Speakers and Those Needing Special Assistance:

If a potential beneficiary does not speak English or needs an interpreter because he/she has a loss of hearing, help to arrange for a translator or interpreter to accompany the potential eligible during the interview. The translator or interpreter may be a relative or friend, or you may know someone in the local social services (or other) state agency office who can also translate or interpret for the potential eligible beneficiaries.

Collect Documents Needed to Verify Information

Potential eligible beneficiaries will need to provide information in order to verify items such as age, income and resources on their application.

The documents required to verify information vary from state to state. Your SHIP office may have a list of required documents. Alternatively, you can call the local social services (or other) agency for the types of documents needed.

When a potential eligible beneficiary submits an application, the applicant should bring the required documentation to the local social services (or other) agency where the application is made. Applicants should be advised to complete the application, even if they do not have adequate documentation.

It is important to remind potential eligible beneficiaries that they should not delay in applying for benefits because they do not have all the records they need. The eligibility worker at the local social services (or other) state agency office may be able to help obtain the needed information.

Once all the documents have been gathered, the process for determining eligibility should take no longer than 45 days.

Checklist of Required Documents

The following provides examples of the types of documents that potential eligibles may need to provide:

- ❑ Proof of identity
- ❑ Proof of income (all sources)
- ❑ Proof of age (e.g., birth certificates)
- ❑ Liquid assets, including checking and savings account statements
- ❑ Real estate assets, e.g., buildings and land other than the primary residence
- ❑ Life and health insurance policies
- ❑ Medicare card
- ❑ Social Security Number
- ❑ Citizenship or Alien Status Record
- ❑ Two references, by individuals not related to the applicant, who can verify their circumstances
- ❑ Other (specify: _____)

Trainer: In the list above, check which documents apply in your state.

Proof of Identity

- ❑ Photo identification
- ❑ Driver's license
- ❑ U.S. Passport
- ❑ Other (specify: _____)

Proof of Age

- ❑ A public record recorded before age 5, or a religious birth certificate recorded before age 5, or any other documents showing applicant's age or date of birth.
- ❑ Other (specify:_____)

Trainer: In the list above, check which documents apply in your state.

Proof of Income

Local social services (or other) state agency offices examine two types of income, Earned and Unearned.

Earned Income: money received from wages or earnings from self-employment.

Unearned Income: money received from any other source, including:

- Social Security benefits
- Veteran's benefits
- Annuities
- Pensions
- State disability
- Unemployment benefits
- Interest income on bank accounts
- Dividends
- Cash from relatives and friends
- Other (specify:_____)

Applicant must produce any records showing source of payment, how often received and amount received, e.g., bank statements, court orders for support, receipts and award letters.

Proof of Financial Resources

- ❑ Bank statements
- ❑ Deeds to property or tax appraisal statements for all property applicant owns, in addition to their primary residence
- ❑ Insurance policies
- ❑ Certificates of deposit
- ❑ Stocks, bonds, mutual funds
- ❑ Burial plot deed
- ❑ Other (specify:_____)

Enrollment in Medicare

- ❑ Medicare card
- ❑ Other (specify:_____)

Social Security Card or Number

- ❑ Applicant must apply for a Social Security Number, if he/she does not have one.
- ❑ Other (specify:_____)

Trainer: In the list above, check which documents apply in your state.

Citizenship or Alien Status Record

If applicant is a citizen, produce one of the following:

- ❑ Birth certificate showing place of birth
- ❑ Religious record of birth or baptism showing U.S. birthplace
- ❑ Naturalization certificate
- ❑ U.S. Passport
- ❑ Certificate of Citizenship
- ❑ Other (specify:_____)

If applicant is not a citizen, he/she should produce an immigration form or certificate showing status.

Trainer: In the list above, check which documents apply in your state.

Appeals Process

If denied coverage, the applicant may file an appeal. If the appeal is successful, the applicant will be eligible for program benefits retroactive to the date of the initial denial.

The appeals process is outlined below:

- An applicant must file a written application within 30 days of the denial in order to appeal a decision. The appeal is filed at the same location that the applicant originally applied for the program. An applicant is guaranteed a hearing.

- The appeal period must be a reasonable length of time, not to exceed 90 days. Individual states may have established their own appeal guidelines. [Check with your local social services (or other) state agency office for more specific information.]

If an applicant needs additional assistance, refer the applicant to the local legal service office or local Area Agency on Aging for legal advice and assistance.

Special Considerations for Applying for QI Programs

There are several important points regarding the QI-1 and QI-2 application process:

- Individuals must submit a new application every year for these benefits.

- It is important to apply for QI benefits as early in the calendar year as possible because the funds for these programs are limited and applications are approved on a first-come, first-serve basis.

- Priority for the following year will be given to those who received benefits during the previous year.

Summary of Module

As a participant, you should now be able to:

- Guide a potentially eligible beneficiary through the enrollment process.
- Explain the appropriate documentation required for enrollment.

Technical Appendix

The table below presents locations or sites (other than the social service agency) where states accept applications. This information is from a survey conducted by the American Public Human Services Association in 1999.

Sites (other than the Medicaid or welfare office) Where States Accept Applications

F = Certified eligibility workers who can make a final eligibility determination at this site
A = Volunteers or providers who simply assist in the completion of an application at this site

State	Hospital	RHC	FQHC	CHC	Homeless Shelter	Other Government Office	Nursing Home	Senior Center	Other
AL									
AK									
AR	F			F					F[2]
AZ									A[1]
CA									
CO									
CT	F								
DC									
DE			F						
FL	F	F	F	F		F			
GA	F								
HI	F/A	A	A						
IA	F/A								
ID							F		
IL									
IN	F								
KS	F/A	F/A	F/A	F/A	F/A	F/A	F/A	F/A	
KY	F/A	A	F/A						
LA*									
MA	A		A	A	A	A	A	A	
MD									
ME*									
MI	A	A	A			A	A		
MN	F				F				F[3]
MS							F		F[4]
MO	F	F							
MT									

Sites (other than the Medicaid or welfare office) Where States Accept Applications

F = Certified eligibility workers who can make a final eligibility determination at this site
A = Volunteers or providers who simply assist in the completion of an application at this site

State	Hospital	RHC	FQHC	CHC	Homeless Shelters	Other Government Offices	Nursing Home	Senior Centers	Other
NC	F	F	F	F		F			
ND									
NE	A	A	A	A	A	A	A	A	
NH*									
NJ*									
NM	F							F/A	
NY								F/A	
OH									
OK*									
OR*									
RI*									
PA	A	A	A	A	A	A	A	A	
SC	F/A	A	A	A	A	A	A	A	
SD									
TN*									
TX	F								
UT	F	F	F	F	F	F	F		F[5]
VA*									
VT*									
WA									
WV	F	A	A	A		A	A	A	
WI	F/A	F/A	F/A	F/A		F/A	F		
WY					A	A	A	A	

RHC (Rural Health Clinics); FQHC (Federally Qualified Health Centers); CHC (Community Health Centers)
* These states did not participate in the survey.

[1] Tribes
[2] AAAs, Center for Youth and Families
[3] Tribes
[4] Court houses, libraries
[5] Senior apartment complexes

Source: Shaner, Heidi. *Dual Eligible Outreach and Enrollment: A View from the States* (Washington, DC: American Public Human Services Association, March 1999).

HCFA Model Application

Place Holder for HCFA Model Application

Place Holder for HCFA Model Application

Place Holder for HCFA Model Application

Place Holder for HCFA Model Application

Place Holder for HCFA Model Application

Place Holder for State-Specific Application

Trainer: Please insert your state's application form.

Module IV Overview

There are numerous benefit programs available to the low-income elderly. This module will inform counselors of the different programs and how to identify potentially eligible individuals. The goal of this module is to give counselors increased knowledge and confidence in 1) knowing that low-income and other programs exist and how to refer clients so that they can receive information on these programs, and 2) identifying beneficiaries who may be eligible for these programs.

Learning Objectives

At the conclusion of this module you will be:

- Familiar with some of the other benefit programs available to the low-income elderly.
- Able to identify elderly people who are eligible for other benefit programs.
- Able to explain how these programs can coordinate with dual eligible programs.

Description of Low-Income Programs and Benefits

Medicare beneficiaries often seek advice and counsel because of financial distress. Counselors should aim to identify the full spectrum of programs and services that can assist low-income Medicare beneficiaries in increasing their financial resources. These beneficiaries may be struggling to pay high medical bills or to purchase prescription drugs while paying for basic necessities such as housing and food.

Assembling a package of benefits through local programs will help to ease the financial stresses facing low-income beneficiaries. Examples of health-related programs include: prescription drug coverage through a state program or a pharmaceutical company, or receiving hearing aids and eyeglasses. Other programs include food stamps, housing, or energy assistance.

The module provides a brief description of programs that may provide additional protection for low-income beneficiaries. Although this module focuses on national programs, counselors should also be familiar with state-specific programs that may help beneficiaries. State programs are often more specific to the needs of that region and can provide a comprehensive package of services. The best way to find out about these programs is to consult the telephone book under community services or contact your local Area Agency on Aging office.

State and Local Service Programs

There are many state and local programs that serve the elderly. State departments (also called "units") on aging, Area Agencies on Aging, and cities, towns, and counties offer programs to assist older adults. Some programs are restricted by age, others are based on income, and some programs have both age and income restrictions. In addition to the programs described in this module, other programs that are available in many states include prescription drug assistance programs, home care programs, state supplement to Social Security benefits, and property and renters relief.

Funding under Title III of the Older Americans Act is provided to states for programs that serve persons 60 years of age and older, regardless of income. Services provided through these grants may include adult day care, in-home services, nutrition programs (home-delivered meals, congregate meals), community services, health services, transportation and legal services. Many towns and counties have similar programs and may also have volunteers who can provide services such as transportation or senior companionship programs.

Please check with your state department on aging, Area Agency on Aging, and/or local social/senior service department for lists of services available.

Health-Related Assistance

Prescription Drug Programs

The pharmaceutical industry has a longstanding tradition of providing prescription medicines free of charge to **physicians** whose patients might not otherwise have access to necessary medicines.

The Pharmaceutical Research and Manufacturers of America (PhRMA) has created a directory that makes it easier for physicians to identify the expanding number of programs available for low-income patients.

The availability of prescription drugs, the quantities available, the application process and eligibility criteria vary from company to company. All programs require physicians to prescribe the medication and certify that purchase of the medication would cause financial hardship. It should be noted that each prescription to be filled requires a separate request, increasing the administrative burden for both the physician and patient.

Patients must ask their individual physicians about possible programs; however, the PhRMA Directory of Prescription Drug Patient Assistance Programs is available at http://www.phrma.org.

Individual states have pharmaceutical assistance programs, which usually require a minimal annual fee. Please elaborate in the box below on the specifics (including contact information) of your individual state program.

HEAR NOW

HEAR NOW is a non-profit organization serving clients throughout the United States. This assistance program has developed one of the largest collections of new and used hearing aids in the country. The hearing aids are distributed to financially needy clients through a nationwide network of "Associates." The program is aimed at those with limited financial resources.

The applicant must have a documented hearing loss. If eligibility is established, two hearing aids will be provided. There is a $30.00 processing fee for each hearing aid received.

To apply or receive more information, call **1-800-648-HEAR (4327)**.

Free Eye Exams

The American Academy of Ophthalmologists provides free eye exams for disadvantaged seniors. Individuals are referred to a participating ophthalmologist within a 50-mile geographic radius of their home. Any condition diagnosed during the first visit is covered at no cost to the patient.

To be eligible for this program, an individual cannot currently be under the care of an ophthalmologist and must be financially needy. The individual may be enrolled in Medicare or other types of insurance, but cannot be enrolled in a Medicare health maintenance organization (HMO).

For more information on this program call **1-800-222-EYES (3997)**.

Donated Dental Services

The National Foundation of Dentistry for the Handicapped runs a program called "Donated Dental Services." This program provides dental services at reduced or no cost to disabled, elderly and chronically ill individuals. There are no income limits for program eligibility, but the individual must not have dental insurance. The dental services are offered on a once-off basis and only for extensive dental work. Covered services do not include a regular dental check up and cleaning.

These services are donated by dentists in all regions of the country, and 24 states have their own individual programs. The national office in Denver, Colorado will provide individuals whose state does not have a program with the name of the nearest dentist and services that are available.

For more information on dental services in your area and an application call **1-800-365-7229**.

Free Hospital Services

Some hospital and nursing home facilities are obligated to provide free care. Under the Hill-Burton Act, non-profit providers received funds to modernize their facilities. In exchange, these providers agreed to give free or reduced charge medical services to persons unable to pay (for a period of 20 years).

Individuals may qualify if their income falls within the federal poverty guidelines published each year. Free or reduced cost care at some facilities is available if an individual's income is up to double (or triple for nursing home services) the federal poverty guideline.

For more information, call the Hill-Burton hotline at **1-800-638-0742**, available in English and Spanish.

Indian Health Service

The Indian Health Service (IHS) is an agency within the U.S. Department of Health and Human Services that is responsible for providing federal health services to American Indians and Alaskan Natives. IHS is also the principal federal health care provider and health advocate for American Indians and Alaskan Natives. The IHS currently provides health services to approximately 1.5 million American Indians and Alaskan Natives who belong to more than 557 federally recognized tribes in 34 states.

Contact your regional IHS office for specific program details and eligibility requirements.

More information is also available on the IHS website located at http://www.ihs.gov.

Federally-Qualified Health Centers

The Bureau of Primary Health Care has four Federally Qualified Health Centers (FQHCs) programs that provide preventive and primary health services to under-served and vulnerable populations in communities across the country. FQHCs receive cost-based reimbursement for Medicare and Medicaid patients as a mechanism to increase primary care services to high-risk populations. The four programs eligible under this form of reimbursement are as follows:

Community Health Center Program

Community Health Centers provide family-oriented and preventive health care services for people living in rural and urban medically under-served communities.

To find the location of the nearest Community Health Program Center, call **301-594-4300**.

Migrant Health Center Program

Migrant Health Care Centers and Migrant Health Programs provide migrant and seasonal farm workers and their families access to comprehensive medical care services with a culturally sensitive focus.

To find the nearest Migrant Health Center, call **301-594-4300**.

Federally-Qualified Health Centers (continued)

Health Care for the Homeless

The Healthcare for the Homeless program delivers primary health care, including mental health and substance abuse services, to homeless persons.

To find the location of the nearest center and its programs, call **1-800-277-3281**.

Public Housing Primary Care Program

The Public Housing Primary Care Program provides residents of public housing with increased access to comprehensive primary health care services. Services are provided on the premises of public housing developments, or at other locations immediately accessible to residents of public housing.

To find the location of the nearest Public Housing Primary Care Program, call **1-888-439-3300**.

Nutrition, Food, and Housing Assistance

Food Stamps

The Food Stamp Program helps low-income people buy the food they need for good health. Elderly or disabled persons with limited incomes may be eligible for assistance. Eligibility is generally set at the federal poverty level. State public assistance agencies administer the program through their local offices. The following rules apply in most states, but a few states may have different rules:

- The amount of food stamps or vouchers one can obtain is based on the Department of Agriculture's Thrifty Food Plan, which is an estimate of how much it costs to buy food to prepare nutritious, low-cost meals for a household. This estimate changes every year to keep pace with food prices.

- A household is defined as a group of people who live, buy food and prepare meals together. If a household passes the eligibility test, the amount of food stamps or vouchers received will depend on the number of people in the household and how much monthly income remains after certain expenses (deductions) are subtracted.

- In general, food stamps or vouchers meet only part of a household's food budget; food stamps or vouchers are intended to be combined with cash in order to ensure adequate food supply.

- In most states, Supplemental Security Income (SSI) and general assistance recipients are automatically eligible for food stamps or vouchers. However, there are several states where enrollment in both programs can hinder the benefits of one or the other. It is best to check with your local Food Stamp office regarding the implications of eligibility in both programs.

To find more information on the Food Stamp Program, contact your local state Food Stamp Program. (Contact information may be found in the Resources Section of the Training Manual.)

Nutrition Program for the Elderly

The Nutrition Program for the Elderly (NPE) helps provide elderly persons with meals through the home-delivered meals programs, or in senior citizen centers and other congregate sites. The NPE is administered by the U.S. Department of Health and Human Services and receives commodity foods and financial support from the U.S. Department of Agriculture's Food and Nutrition Service (FNS).

People 60 years of age or older and their spouses, regardless of age, are eligible for NPE benefits. In addition, disabled people who live in elderly housing facilities may receive meals from NPE. There are no income requirements to receive meals. Each recipient may contribute as much as he/she wishes toward the cost of the meal, but meals are free to those who cannot make any contribution.

Since the program is administered at the state level,
contact the distributing agency in your state for more information.
(Contact information may be found in the Resources Section
of the Training Manual.)

Government-Assisted Housing

Government-assisted housing is available to the low-income elderly through three major programs described below. Since there is a shortage of government-assisted housing, it is difficult for all applicants who meet eligibility requirements to receive assistance. Moreover, the availability of housing assistance varies from area to area.

Public Housing is low-income housing in multi-unit complexes that typically requires tenants to pay no more than 30 percent of their monthly income for rent. This housing is available to elderly and disabled low-income applicants who do not exceed published income levels (dependent on the number of people in their household).

Section 8 Rental Certificates allow low-income persons (including the elderly and disabled) to choose where they want to live, subject to Housing and Urban Development (HUD) standards, by providing rental certificates that limit the tenant's rent to 30 percent of their adjusted monthly income. To be eligible, an individual may not have income that exceeds 50 percent of the median income for the area.

Contact the local housing authority in the area you wish to live, if interested in public housing or Section 8 assistance.

Section 202 Housing is senior citizen housing, usually with supportive services such as meals, transportation, and accommodations for the disabled. This program is administered by private, non-profit organizations and consumer cooperatives. Eligibility is open to low-income households with at least one person who 62 years of age or older, or a person with a disability.

Contact your local housing authority or your Agency Area on Aging for a list of such complexes in your area, if interested in Section 202 Housing.

Energy Assistance

LIHEAP (Low-Income Home Energy Assistance Program)

LIHEAP assists eligible, low-income households in meeting the heating or cooling portion of their residential energy needs. This includes households with incomes that do not exceed either 150 percent of the federal poverty level or 60 percent of the particular state's median income.

Individuals who receive assistance from the Food Stamp program, SSI, and certain needs-tested veteran benefits are eligible.

Depending on the individual grantee, LIHEAP funds can be used for the following types of energy assistance:

- Heating assistance,
- Cooling assistance,
- Energy crisis intervention, and
- Low-cost residential weatherization and other energy-related home repair.

The application for LIHEAP assistance, eligibility, types of assistance available and benefit levels vary among LIHEAP programs.

You must apply for assistance from your local state LIHEAP or Indian Tribal organization.

Information can also be accessed on the LIHEAP website, located at http://www.acf.dhhs.gov under "Programs."

Supplemental Income

Earned Income Tax Credit

The Earned Income Tax Credit (EITC) is a tax benefit for low- to moderate-income workers. Although the ages of eligibility are 25 to 64, individuals may still qualify if they file jointly and a spouse is within the age limit. Individuals who do not owe taxes may still be eligible for the EITC and receive a check from the Internal Revenue Service (IRS).

For more information on eligibility, call the IRS toll free at **1-800-829-1040**.

Supplemental Security Income

Supplemental Security Income (SSI) is a federal program for older people with low incomes, the blind and individuals with disabilities who have little or no income and resources. To qualify for SSI, individuals must have limited income and assets:

- Either over 65 years of age, blind or disabled;
- Have monthly income for non-workers that do not exceed $520 for an individual or $771 for a couple;
- Have monthly income for workers that do not exceed $1,085 for an individual and $1,587 for a couple;
- Have resources that do not exceed $2,000 for an individual and $3,000 for a couple.

The maximum monthly SSI benefit in all states is $500 for a single person or $751 for a couple. Some states may supplement this amount. This amount increases each year by the amount of the Social Security cost of living adjustment (COLA).

Being eligible for SSI means that an individual receives a monthly benefit and, depending on the state where you live, the following benefits and services:

- Medicare premiums are paid (all states),
- Medicaid (available in most **but** not all states), and
- Food Stamps.

For more information on applying for benefits,
call **1-800-772-1213** to set up an appointment with a
Social Security representative.

Veteran's Benefits

If an individual has or can obtain both Medicare and Veteran's benefits, he/she may choose to receive treatment under either program. But, he/she must choose one program or the other each time care is needed. Medicare cannot pay for the same service paid for by the Veterans Administration (VA), nor can the VA pay for the same service paid for by Medicare. However, there are instances when Medicare and VA can each contribute to the payment. For instance, if the VA authorizes a beneficiary to obtain hospital services in a hospital that is not a VA hospital but does not pay for all the services received during the stay, Medicare can pay for Medicare-covered services for which the VA does not pay.

Questions about Veterans payments working in conjunction with Medicare should be directed to the individual carrier who pays the beneficiary's Medicare claims in your state.

Additional Reference and Information

Eldercare Locator

In 1993, the National Association of Area Agencies on Aging established the nationwide Eldercare Locator, a toll-free number for identifying the information and referral services provided by State and Area Agencies on Aging. Individuals who call this toll-free line have access to more than 4,800 state and local information and referral service providers identified for every zip code in the country. This line can provide information on a broad range of subjects, including: adult day care, legal services, elder abuse and protective services, Medicare and Medicare supplemental insurance (or "Medigap") information, tax assistance and transportation. The number is available weekdays from 9:00 a.m. to 8:00 p.m. (Eastern Standard Time).

Eldercare Locator Phone Number is **1-800-677-1116** and
is available weekdays from 9:00 a.m. to 8:00 p.m. EST (Eastern Standard Time).

Transportation

The National Transit Hotline can provide the names of local transit providers who receive federal money to provide transportation to the elderly and people with disabilities.

National Transit Hotline Number is **1-800-527-8279**.

Additional Information for SHIP Counselors

There are several computer-based programs available to help SHIP coordinators and counselors determine potential eligibility for both public (and private) assistance programs for individuals with low-income. The computer program matches the answers received from the potential eligible to the complex eligibility criteria for a range of assistance programs. Generally, these programs are meant to provide an estimate of the likelihood of receiving program benefits.

For example, the Benefits Outreach & Screening Software (called BOSS) is a software program (created by United Seniors Health Cooperative) designed to check a person's eligibility for an unlimited number of community resources and job training opportunities. The software prints a report detailing how, when, and where to apply.

For more information on obtaining BOSS software,
contact the United Seniors Health Cooperative at **202-783-0588**.

Ways to Recognize Potential Eligibility for Low-Income Programs

Many individuals are unaware of programs and resources that help low-income individuals. There are a number of assistance programs for the low-income elderly such as those described earlier in this module.

For counselors, one main objective is to recognize a person's need and whether they may be eligible for different programs. The basic eligibility requirements have been outlined for the different programs.

This section provides some hints for counselors to identify potential enrollees.

- Establish a rapport with the potential dual eligible.
- Closely examine the person's background and needs. This can give valuable clues as to which programs they may be eligible for.
- Listen carefully. What may seem like passing comments can give the counselor insight into that person's life, background and needs.

Example:

You are talking with a potential dual eligible and he/she mentions that last month's income was almost totally applied to rent instead of paying for their Medicare supplemental insurance premiums. This should be a signal to the counselor to screen the person for government-assisted housing, or refer them to the local housing authority for help.

Keep in mind that potential dual eligibles have a limited income. This fact in itself makes them likely candidates for other forms of assistance.

Issues in Coordinating with Low-Income Programs

The majority of the programs discussed above may work in conjunction with QMB, SLMB, QI and QDWI. Each program, however, has specific eligibility requirements.

Those requirements are given in general terms in earlier sections of this module, but the best way to check for state-specific eligibility is to contact representatives of the specific program. Alternatively, your state SHIP office may have compiled summary eligibility information for counselors to use.

It is also crucial to remember that in applying for one program, the income level for the individual may change, and thus change his/her eligibility for another program. Conflicts may arise. For this reason, **never** promise or assure an individual that they are definitely eligible for benefits, or that they will receive them.

When beneficiaries begin to receive one program, their income level may change, and thus change his/her eligibility for another program.

Never promise that someone is definitely eligible. Say that they **may** be eligible.

Coordination with Other Health Plans

Medicaid and Medicare Working Together

Medicare directly reimburses participating providers. When Medicaid pays for medical costs not paid for by Medicare, it also directly pays providers. Beneficiaries should not receive any bills, unless Medicare or Medicaid are not responsible for those costs.

Medicare generally reimburses before Medicaid. Medicaid is the **payer of last resort**, so any other insurance plans, including Medicare, employer-based or private non-group, must pay before Medicaid will pay. Most physicians are certified as Medicare providers but not all are certified under Medicaid. Beneficiaries must receive health services from providers who also accept Medicaid payments.

If you are a Medicare beneficiary who is also eligible and enrolled in QMB or the full Medicaid program, the payment by both Medicare and Medicaid will be for the full cost of covered services. The Balanced Budget Act of 1997 eliminated balance billing under Medicare for any Medicare beneficiary who is enrolled in the QMB program (see the Technical Appendix in this module for more information). The beneficiary should not have to make additional payments for those services. However, since Medicaid is a state administered program, there may be variations from state to state.

Counselors should check with the state Medicaid agency or refer beneficiaries to the social services (or other) agency office for answers to detailed cost-sharing questions.

Managed Care for Dual Eligibles

Approximately 4.5 percent of dual eligibles were enrolled in Medicare-managed care plans in 1996. Seventeen states required or allowed dual eligibles to enroll in Medicaid managed care in 1997. While the number of dual eligibles in managed care arrangements is low, it is likely to increase in the future.

Enrollment of dual eligibles in managed care introduces an additional layer of complexity. The following is intended to help counselors gain an understanding of some general facts about dual eligibles enrolled in managed care arrangements.

For Medicare beneficiaries enrolled in Medicare fee-for-service:

- Beneficiaries may be able (depending on which populations are covered) or required to enroll in Medicaid managed care for dual eligible benefits (i.e., premiums, deductibles and coinsurance).
- The value of dual eligible program benefits does not change.
- Counselors should explain to beneficiaries who live in areas with mandatory Medicaid managed care that they should enroll in their preferred health plan, or they may be automatically enrolled in a health plan, at the discretion of the state.

For Medicare beneficiaries enrolled in Medicare managed care:

- Beneficiaries may be able (depending on which populations are covered) or required to enroll in Medicaid managed care for dual eligible benefits (i.e., premiums, deductibles and coinsurance).
- The value of benefit changes: Medicare Part B premiums are paid by Medicaid; however, managed care enrollees generally have lower cost-sharing requirements and, consequently, less is paid by Medicaid.
- Counselors should explain to beneficiaries who live in areas with mandatory Medicaid managed care that they should enroll in their preferred health plan, or they may be automatically enrolled in a health plan, at the discretion of the state.

Medicare Supplemental Insurance and QMB

Medicare beneficiaries who are also eligible for QMB generally do not need Medicare supplemental insurance (known as "Medigap"). Medicaid covers the out-of-pocket costs of Medicare covered services and the added cost of the Medicare supplemental insurance policy may not be worth the value of the benefits received.

If a QMB beneficiary has Medicare supplemental insurance coverage, this individual may have their supplemental insurance company put their policy "in suspension" (rather than canceling the policy) for up to 24 months, or two years while enrolled in the QMB program. The beneficiary does not incur any penalties.

The suspension of the Medicare supplemental insurance policy must be initiated within 90 days of becoming enrolled in the QMB program. The individual must contact their Medicare supplemental insurance carrier to initiate the "suspension" of Medicare supplemental insurance coverage.

During the suspension period, the Medicare supplemental insurer does not charge premiums or provide any benefits to the beneficiary.

Subsequently, if a beneficiary is no longer eligible for QMB, the Medicare supplemental insurance insurer must reinstate the policy coverage (within the given 24-month period). Reinstatement must occur within 90 days of losing eligibility. Medicare supplemental insurance coverage will be effective as of the date of termination of QMB eligibility, and premiums must be paid from that effective date. The beneficiary must contact their Medicare supplemental insurance carrier to reinstate coverage.

Individuals who qualify for QMB may choose to put their Medicare Supplemental Insurance (or "Medigap" policy) in suspension for up to two years.

Medicare Supplemental Insurance and SLMB and QI Programs

Individuals participating in the SLMB and QI programs should explore their health insurance options. Beneficiaries may want to purchase Medicare supplemental insurance, if they can afford to do so. Because these programs only pay for the Medicare Part B premium, purchasing a Medicare supplemental insurance policy will help to cover Medicare Part A and Part B deductibles and co-insurance amounts.

In addition, counselors may want to discuss managed care options in your state as another health insurance option for those participating in the SLMB and QI programs.

Summary of Module

In this module you learned:

- About various benefit programs aimed at low-income elderly persons,
- How to recognize potential eligibility for a variety of low-income programs,
- How these programs can work in conjunction with dual eligible programs, and
- That dual eligibles may be covered by managed care arrangements.

Technical Appendix

QMB and Balance Billing

The Balanced Budget Act of 1997 eliminated balance billing under Medicare for any Medicare beneficiary enrolled in the QMB program in two ways. First, the legislation prohibited balance billing of beneficiaries in the cases where states use state Medicaid fee limits as the basis for payment. Specifically the legislation states:

- The amount of payment made by Medicare plus the amount of payment by Medicaid (if any) shall be considered to be payment in full for the service for purposes of applying any limitation under Medicare on the amount the individual enrolled in the QMB program may be billed or charged for the service;

- The individual enrolled in the QMB program has no legal liability for payment to a provider or health maintenance organization (HMO) for the service; and

- If a provider or HMO imposes an excess charge on an individual enrolled in the QMB program, that entity is subject to any lawful sanction that may be imposed under Medicare or Medicaid.

However, a provider or HMO may pursue payment for Medicare cost-sharing from a Medicare supplemental policy or an employer retiree health plan on behalf of the individual enrolled in QMB.

Second, the legislation precluded Medicare providers (both Medicare providers and non-Medicare providers) from imposing any charge that is prohibited.

Module V Overview

This module will describe the barriers to awareness and enrollment in the QMB, SLMB, QI and QDWI programs. It will also provide an overview of activities being undertaken in many states to identify potential dual eligible beneficiaries, to raise awareness and increase motivation to enroll into these programs.

Learning Objectives

At the conclusion of this module, you will:

- Recognize barriers to awareness and enrollment for dual eligible beneficiaries.
- Learn about different ways to identify potential dual eligible beneficiaries.
- Learn about different ways to raise awareness and increase motivation for individuals to apply for dual eligible programs.

Barriers to Awareness and Enrollment

Research indicates that there are many barriers to participation in dual eligible programs. According to a recent report sponsored by HCFA, 55 percent (of 6.5 million potential eligibles) were enrolled in the QMB program in 1996. Only 16 percent (of 1.8 million potential eligibles) were enrolled in the SLMB program. A complicated and burdensome enrollment process and the stigma associated with public benefit programs have been cited as reasons for low enrollment in these programs.

The following have been identified as barriers to awareness of, and enrollment in, dual eligible programs:

Structural Barriers

- **Lack of Knowledge:** Potential dual eligible beneficiaries simply do not know that programs are available to help pay for out-of-pocket health care expenses. Oftentimes, these beneficiaries lack a basic understanding of the Medicare program.

- **Lack of Information on Eligibility Criteria:** Potential dual eligible beneficiaries often do not understand the income and financial resource eligibility criteria. For example, they are often confused about which items are counted as financial resources, for example.

- **Burdensome Application Process:** Potential dual eligible beneficiaries are often intimidated by the complicated application and verification process. In addition to the complicated application process, there is a perception that the social service agency eligibility workers are rude, impersonal and sometimes prejudiced.

Beneficiary Perceptions

- **Welfare Stigma:** Potential dual eligible beneficiaries feel that there is a stigma associated with participation in welfare or means-tested programs.

- **Personal Perceptions:** They may not feel that they need help, or beneficiaries may not want to disclose sensitive financial information to individuals outside their immediate family.

- **Benefits Too Low:** Potential dual eligible beneficiaries feel that the benefits they would receive are not worth the trouble of applying.

- **Fear of Losing "What They Have":** Potential dual eligible beneficiaries believe that applying for these benefits jeopardizes other benefits and financial assets.

- **Mistrust of Government Agencies:** Many individuals, including non-English speaking and minority populations may feel uncomfortable with government-sponsored programs.

- **Rejection of Past Application:** Applicants denied benefits often do not know about the appeals process or that they can re-apply when their financial circumstances change.

Social and Demographic Barriers

- **Access Problems:** Individuals with disabilities and homebound beneficiaries may not have transportation to reach the local social services (or other) state agency office. In addition, potential dual eligible beneficiaries living in rural areas may have limited access to local assistance offices.

- **Communication Issues:** Language or literacy barriers may lower an individual's awareness of dual eligible programs. Local social services (or other) state agency offices may also pose communication problems due to a lack of multi-lingual staff.

- **Comprehension Problems:** Potential dual eligible beneficiaries may not understand the health care options available. In addition, immigrants may not be familiar with the U.S. health system, or understand health insurance concepts.

Ways to Overcome Barriers

Identifying Potential Dual Eligible Beneficiaries

As a counselor, there may be opportunities for you to identify potential dual eligible beneficiaries. Your interaction with beneficiaries may include face-to-face meetings at your local office, telephone consultations, or visits to local senior centers or other places where many beneficiaries assemble. Rely on your presence in and knowledge of your community, as it is also important in helping to identify potential dual eligible beneficiaries.

The following are some strategies that you can employ to identify potential dual eligible beneficiaries:

- When screening individuals for other benefit programs, simultaneously screen them for the QMB, SLMB, QI and QDWI programs. You may be able to screen beneficiaries who are seeking assistance in other public assistance or health-related programs. Take into account their level of income and financial resources to determine if they are potentially eligible.

- Request referrals from your local Social Security office or Area Agency on Aging (AAA). It is important to coordinate with the local Social Security Administration (SSA) and the AAA, as these agencies are a major source of referrals.

  SSA is a "point of entry" for newly enrolled Medicare beneficiaries and for workers who become disabled and apply for disability coverage. The Agency is also responsible for determining eligibility for Supplemental Security Income (SSI). Thus, SSA has direct contact with potential dual eligible beneficiaries as well as financial information that can be used in outreach efforts.

  Local AAAs are another "point of entry" for potential dual eligible beneficiaries. AAAs have developed and coordinated services such as home-delivered meals, case management, transportation, legal services and information and assistance to older persons.

- Increase your network of individuals in trusted, community-based organizations (for example, churches, local clinics or Home-Delivered Meals) who can provide referrals. For members of the aged community, there are many opportunities to informally spread the word about programs to help beneficiaries pay for some of their health care costs.

Example:
SHIP coordinators and counselors may have opportunities to describe dual eligible programs and types of assistance that SHIP offices provide when visiting senior centers or attending health fairs.

Also, remember that you may encounter individuals who often come in contact with potential dual eligible beneficiaries who also need information regarding QMB, SLMB, QI and QDWI. These individuals may be caregivers, adult children or grandchildren of potential eligibles, or providers in the community.

Raising Awareness and Increasing Motivation

After identifying potential dual eligible beneficiaries, your role is to educate them on the program and its benefits, and motivate them to take action and apply for QMB, SLMB, QI or QDWI.

You are already helping them by providing one-on-one counseling. Beneficiaries generally prefer this type of assistance to clarify program rules or ask additional questions. In this setting, you will be able to heighten their comfort level with the enrollment process or basic ways to navigate the system. In addition, this one-on-one counseling situation already lessens the anxiety that some beneficiaries may have in discussing programs and benefits in front of their peers.

Listed below are several general pointers for educating potential dual eligible beneficiaries about the benefits of the programs and motivating them to enroll.

- Explain that more income will be available for other living expenses such as prescription drug costs. Give an actual dollar figure and present the benefits tangibly. For example, a beneficiary has an extra $45.50 a month (or $546 per year in 2000) in their pocket, if they qualify for SLMB benefits.

- Be sensitive to the "welfare stigma" sometimes associated with the dual eligible programs. Present programs as a benefit entitlement -- health care not welfare.

- Emphasize that dual eligible programs will help the beneficiary to stay or get healthy and provide the security of access to a comprehensive health care program.

- Do not say "QMB or SLMB" -- it means nothing to beneficiaries. Ask if beneficiaries have questions about Medicare or health care. Refer to dual eligible programs as "medical assistance".

- Connect these benefits to the receipt of other benefits. If they are already receiving a benefit, they are more likely to sign up for an additional benefit.

- Provide written materials to beneficiaries for future reference; some beneficiaries may feel more comfortable reading materials about the programs prior to having a face-to-face meeting.

- Stress that QI programs are available for a limited amount of time. Potentially eligible beneficiaries should take advantage of the program **now.**

- Avoid certain terms that would make the potential dual eligible beneficiary feel uneasy or uncomfortable:

Instead of:	Use:
Buy-In Program and QMB, SLMB, QI or QDWI	Medical assistance
Welfare	Temporary assistance or financial assistance
Acronyms	Use full name to avoid confusion or "programs that help people with Medicare pay for health care costs"
Handicapped	Disabled
Disabled Person	Person with a disability
Do you receive welfare?	Are you eligible for Medicare? Do you have income below $___? Do you need help with your medical bills?

Suggestions on Overcoming Barriers

Welfare Stigma

Many older individuals feel that there is a stigma associated with participation in welfare or public benefits programs. Elderly beneficiaries are proud and may feel embarrassed about receiving money that they feel they have not earned. In addition, some older beneficiaries may continue to struggle rather than face what they perceive as humiliation by applying for public benefits or may feel that receiving benefits may take away from another person that is more needy.

How can you help?

The messages that you convey to the beneficiary will be important in overcoming this barrier.

- Emphasize that these benefits are not charity. Beneficiaries who qualify for these programs are entitled to benefits.

- Refer to the dual eligible programs as medical programs that help beneficiaries with their health care bills. Inquire if beneficiaries need helping paying for their medical bills, such as their prescription drugs. You may want to emphasize that the actual dollar value of the benefit or the extra money may be used to pay for their necessities, including health-related costs.

- Stress that they have contributed to these programs by paying taxes during their working years.

Beneficiaries often will not want to visit their local social services office because of the association with welfare. These offices may also be overwhelming to older individuals, as they are often noisy and chaotic. Furthermore, beneficiaries may perceive eligibility workers at the social service agency as unfriendly, impatient and disrespectful. Beneficiaries may have had previous negative encounters (such as a rejected past application) with the social service agency or their peers may have told them about their negative experiences.

How can you help?

- If your state allows alternative application sites, inform beneficiaries that they may apply at locations other than the social service agency. Inform them of the specific location sites, and discuss if they are allowed to complete applications by mail, by telephone or by fax. [Refer to pg. III-7 in Module 3]

- If the beneficiary must go into the social service agency, review the application process so beneficiaries are familiar and comfortable with the process. This explanation will help beneficiaries know what to expect, what problems they might encounter, and how to deal with potential obstacles.

- Counteract negative stereotypes of the social service agency with your stories of positive interactions or name a helpful eligibility worker with whom you have developed a relationship.

- For those beneficiaries who have had a past application rejected, inform them first that their eligibility for dual eligible programs is not affected by previous applications for assistance. Second, advise beneficiaries that they have a right to appeal the agency's application decision and then inform them of the appeals process.

- If time permits, offer to accompany them to the social service agency and help them apply.

Fear of Government Agencies

Many older individuals are afraid or uncomfortable interacting with large bureaucratic, government agencies. They may have had negative experiences in the past and do not want to bother applying. In addition, many immigrants have come from countries with a history of undemocratic regimes, resulting in mistrust of the government and being uncomfortable about providing personal information.

How can you help?

- Remind beneficiaries that the government was created for the people by the people.

- Be sensitive to an immigrant's past experience with their former government and discuss the differences between their former government and our government.

- Some beneficiaries may not have much exposure to the health care system or some immigrants may not be familiar with the U.S. health care system. You should provide a brief overview of the health care system, so beneficiaries are comfortable with the system.

- Emphasize that any information they provide is confidential and will not be shared with anyone.

- Provide beneficiaries with information on how they can get assistance from non-government sources.

Access Problems

Many people do not apply because they lack transportation to the application sites. Often public transportation is very limited or beneficiaries live in geographically isolated locations. Some individuals are unable to leave their homes because of their physical condition.

How can you help?

- Depending on your state, the applicant may be able to apply by telephone, by mail or by fax. [See refer to pg. III-8 in Module 3.]

- Advise beneficiaries that the social services (or other) agency may be able to send an eligibility worker for a home visit to a homebound person (check with the agency if this option is available in your state). Alternatively, some community-based organizations (including your SHIP) may provide in-home assistance.

- Inform beneficiaries of local agencies that can provide transportation for older individuals.

Personal Information

Older individuals may be unwilling to provide their personal and financial information because they do not want to share this type of sensitive information.

How can you help?

- Establish a rapport with beneficiaries and let them know beforehand that you will be asking for some personal information that is necessary in order to determine if they are potentially eligible for the programs.

- Emphasize that your conversation is confidential and that it will not be shared with anyone.

- If the beneficiary is still unwilling to provide financial information, establish a range. Ask for example "do you think your financial resources or assets are greater than $4,000?" or "is your monthly income greater or less than $716 (for QMB benefits in 2000)?"

- As a last resort, give them a copy of the screening tool, review the tool and let beneficiaries know that they can self-screen for benefits. Offer your assistance if they have more questions.

Summary of Module

In this module you learned:

- The barriers to awareness and enrollment for dual eligibles
- Methods of overcoming these barriers
- Means of identifying potential eligibles
- Techniques to raise awareness and increase motivation for individuals to apply for assistance programs

Technical Appendix

Low-Income Medicare Beneficiaries Eligible for, but not Receiving, Buy-in

State	Number of QMB + SLMB Eligibles for Buy-in	Number of QMB + SLMB Eligibles Not Receiving Buy-in[1]	Percentage of QMB + SLMB Eligibles Not Receiving Buy-in[2]
Alabama	209,000	92,000 - 100,000	43.9 – 48.0
Alaska	*	*	*
Arizona	118,000	70,000 – 75,000	59.6 – 63.3
Arkansas	139,000	66,000 – 74,000	47.2 - 53.0
California	826,000	74,000 – 100,000	8.9 – 12.1
Colorado	52,000	5,000 – 11,000	9.3 – 20.6
Connecticut	63,000	18,000 – 28,000	28.9 – 43.4
Delaware	21,000	13,000 – 14,000	61.5 – 66.8
District of Columbia	32,000	18,000 – 19,000	56.6 – 60.5
Florida	547,000	252,000 – 275,00	46.0 – 50.2
Georgia	249,000	88,000 – 103,000	35.4 – 41.5
Hawaii	32,000	14,000 – 16,000	44.1 – 48.6
Idaho	22,000	8,000 – 10,000	38.4 – 45.8
Illinois	325,000	198,000 – 226, 000	61.0 – 69.5
Indiana	156,000	87,000 – 101,000	55.6 – 64.7
Iowa	43,000	** – 7,000	** – 15.2
Kansas	69,000	35,000 – 42,000	50.3 – 60.4
Kentucky	149,000	49,000 – 58,000	32.8 – 38.7
Louisiana	176,000	70,000 – 83,000	39.8 – 47.5
Maine	48,000	18,000 – 21,000	37.1 – 43.7
Maryland	127,000	72,000 – 82,000	56.8 – 64.2
Massachusetts	218,000	94,000 – 113,000	43.2 – 52.9
Michigan	226,000	103,000 – 118,000	45.4 – 51.9
Minnesota	86,000	36,000 – 46,000	41.7 – 53.7
Mississippi	111,000	10,000 – 17,000	9.0 – 14.9

Low-Income Medicare Beneficiaries Eligible for, but not Receiving, Buy-in

State	Number of QMB + SLMB Eligibles for Buy-in	Number of QMB + SLMB Eligibles Not Receiving Buy-in	Percentage of QMB + SLMB Eligibles Not Receiving Buy-in
Missouri	144,000	72,000 – 85,000	50.0 – 59.3
Montana	24,000	13,000 – 15,000	54.9 – 62.6
Nebraska	39,000	23,000 – 27,000	60.1 – 68.6
Nevada	43,000	27,000 – 29,000	63.0 – 65.8
New Hampshire	17,000	12,000 – 13,000	68.6 – 75.6
New Jersey	195,000	70,000 – 86,000	35.8 – 44.1
New Mexico	70,000	38,000 – 40,000	53.6 – 56.8
New York	476,000	148,000 – 192,000	31.0 – 40.4
North Carolina	270,000	71,000 – 86,000	26.5 – 31.9
North Dakota	20,000	15,000 – 16,000	75.0 – 80.1
Ohio	393,000	233,000 – 264,000	59.4 – 67.1
Oklahoma	125,000	68,000 – 77,000	54.3 – 61.1
Oregon	88,000	39,000 – 43,000	44.6 – 48.8
Pennsylvania	356,000	202,000 – 231,000	56.6 – 64.8
Rhode Island	43,000	28,000 – 31,000	64.6 – 72.4
South Carolina	152,000	51,000 – 54,000	33.5 – 35.7
South Dakota	22,000	11,000 – 13,000	49.2 – 59.2
Tennessee	176,000	19,000 – 33,000	10.7 – 18.9
Texas	684,000	370,000 – 404,000	54.0 – 59.1
Utah	22,000	9,000 – 10,000	38.7 - 47.0
Vermont	19,000	6,000 – 8,000	34.1 – 40.0
Virginia	224,000	122,000 – 131,000	54.4 – 58.7
Washington	181,000	99,000 – 107,000	54.8 – 59.2
West Virginia	99,000	59,000 –63,000	59.5 – 63.4
Wisconsin	109,000	44,000 – 58,000	39.9 – 52.7
Wyoming	9,000	4,000 – 5,000	44.3 – 53.1
Total	8,044,000	3,343,000 – 3,860,00	41.5 – 47.9

Notes:

[1]This column presents a high and low range rounded to the nearest 1,000 of QMB and SLMB eligibles not receiving the buy-in who, as a result, are experiencing deductions in their Social Security checks.

[2]This column presents a high and low range percentage of QMB and SLMB eligibles not receiving buy-in. The percentages in this column are calculated from data which have not been rounded. As a result, they may not match percentages calculated from previous columns due to rounding error.

*We do not report for Alaska due to insufficient sample sizes.

**Less than 1,000.

Source: Shortchanged: Billions Withheld From Medicare Beneficiaries. A Report by Families USA Foundation, 1334 G Street, N.W. Washington, DC 20005. July 1998.

Profile of Dual Eligibles

A recent report sponsored by HCFA profiled the characteristics of the enrolled and non-enrolled dual eligibles, specifically those potentially eligible for the QMB and SLMB programs. The primary data source used in the study is the Medicare Current Beneficiary Survey in 1996.

The key findings of the report include:

General Findings

- Almost one-fourth (24.1 percent) of the disabled and elderly non-institutionalized Medicare population is estimated to be eligible for either QMB or SLMB or was enrolled in a "Buy-In Program" in 1996.
- Approximately 52.7 percent of beneficiaries eligible for the QMB or SLMB programs did not participate in these programs in 1996. About 45.3 percent of Medicare beneficiaries estimated to be eligible for the QMB program were not enrolled in 1996, and 84.3 percent of those estimated to be eligible for the SLMB program were not enrolled.
- Outside of economic measures, being female, disabled, low education, part of a non-white racial or ethnic group, single, or living in a rural area or a region outside of the Midwest was associated with a higher likelihood of being eligible for the QMB and SLMB programs in 1996. Beneficiaries with lower health status and less access to care were also more likely to be eligible for these programs.
- Beneficiary characteristics with the greatest range in eligibility estimates (outside of economic measures) were:

  - ❖ Age: 72 percent of beneficiaries 18 to 44 years old were estimated to be eligible versus 18 percent of those 65 to 69 years old;

  - ❖ Education: 66 percent of beneficiaries with only a 5th grade education or less were eligible versus 5 percent of those with education beyond high school;

  - ❖ Race/Ethnicity: 60 percent of Hispanic beneficiaries were eligible versus 17 percent of non-Hispanic White beneficiaries; and

- Living Arrangement: 56 percent of beneficiaries who lived with relatives other than their children were eligible versus 12 percent of beneficiaries who lived with their spouse.

QMB Profile

A 1996 comparison of QMB-eligible beneficiaries who did not participate in the program with those who did participate reveals the following statistically significant differences between the two groups. Compared with participating QMB eligibles, non-participating QMB eligibles:

- Had somewhat higher representation in the oldest age category (80 years or older);
- Were over-represented in the white, non-Hispanic subgroup;
- Were substantially more likely to be married;
- Were slightly more likely to be living in urban rather than rural areas;
- Were over-represented in the Northeast and Midwest U.S. Census regions;
- Had slightly higher education levels;
- Were overwhelmingly less likely to be Social Security Income (SSI) or welfare program income recipients;
- Had higher home ownership rates;
- Reported being in much better health and were much less likely to have had an outpatient hospital visit in 1996;
- Were substantially more likely to have privately-purchased supplemental insurance; and
- Were more likely to be enrolled in a Medicare Health Maintenance Organization (HMO).

Eligible beneficiaries with the lowest estimated QMB participation rates:

- Had private supplemental insurance (15 percent);
- Were enrolled in a Medicare HMO (22 percent);
- Did not receive SSI (30 percent);
- Owned their home (35 percent); and/or
- Were married (39 percent).

Eligible beneficiaries with the highest estimated QMB participation rates:

- Were disabled and younger than 44 years old (less than 18 years old – 100 percent; 18 to 44 years old – 76 percent);
- Had SSI income (89 percent) or welfare income (84 percent);
- Identified themselves as being of "other" racial or ethnic descent (71 percent)[1];
- Rented their home (68 percent); and/or
- Were in worse health than other beneficiaries (self-reported poor health -- 67 percent; limitations in two Activities of Daily Living (ADLs) – 68 percent).

[1] Other races and ethnicities include beneficiaries who do not identify themselves as African American, Hispanic, or White non-Hispanic.

SLMB Profile

A comparison of SLMB-eligible beneficiaries who did not participate in the program with those who did participate in 1996 reveals the following statistically significant differences between the two groups.[2] Compared with participating SLMB eligibles, non-participating SLMB eligibles:

- Had somewhat higher representation in the oldest age category (80 years or older);
- Were substantially more likely to be married;
- Were less likely to be welfare program income recipients;
- Had higher home ownership rates;
- Reported being in much better health and were much less likely to have had an inpatient hospital stay, outpatient hospital visit, or home health visit;
- Were less likely to have had a flu shot or to have a regular place for care; and
- Were substantially more likely to have privately-purchased supplemental insurance.

[2] These differences were all statistically significant at the 5 percent (or less) level of confidence in a Chi-square test of independence.

Eligible beneficiaries with the lowest estimated SLMB participation rates:

- Reported excellent health (5 percent) or very good health (8 percent);
- Had private supplemental insurance (5 percent);
- Had no regular place of care (8 percent);
- Owned their home (10 percent); and/or
- Identified themselves as being of Hispanic descent (10 percent).

Eligible beneficiaries with the highest estimated SLMB participation rates:

- Reported receiving SSI income (44 percent) or welfare income (58 percent);
- Used health services (had a hospital stay – 24 percent;
- Had a SNF stay – 25 percent; had a home health visit – 25 percent);
- Were disabled and 18 to 44 years old (29 percent);
- Did not have private supplemental insurance (23 percent); and/or
- Rented their home (22 percent).

HCFA Dual Eligible Activities

The Health Care Financing Administration (HCFA) is addressing the requirements of the Government Performance Results Act (GPRA) through development of a number of performance measures that the Agency must meet. One important GPRA measure is to increase enrollment of eligible beneficiaries in all programs designed to assist low-income elderly and disabled persons with Medicare premiums and cost sharing amounts.

HCFA has undertaken a number of activities to date. These include direct beneficiary education, as well as activities designed to help understand why potential beneficiaries are not enrolled in the dual eligible programs and the steps needed to assist in their enrollment. HCFA is working on a number of projects to meet the Agency's GPRA goals. Some of these are:

- HCFA sponsored a conference, "Reach Out: A Cooperative Effort by Stakeholders" in March 1999. The conference, held in Arlington, Virginia, was attended by approximately 200 representatives from states, beneficiary representative organizations, and other governmental and private sector organizations with an interest in identifying and enrolling potential dual eligible beneficiaries.

- A dual eligible website (at http://www.hcfa.gov/medicaid/dehmpg.htm) was developed to provide a clearinghouse of information on dual eligible beneficiaries. This site provides information for Medicare beneficiaries about programs that can help pay for their Medicare out-of-pocket expenses. In addition, it provides policy and technical information for Federal, State, local and beneficiary advocates and representatives interested in learning more about the various dual eligible programs.

- HCFA developed an interactive resource guide on CD-ROM, "Resources for Reaching Out" to promote understanding among persons who are eligible for both Medicare and Medicaid, and to encourage participation in programs that provide financial support for health care and insurance costs for persons with low incomes. The resource guide can help organizations design and execute strategies and activities to promote enrollment in programs that can save beneficiaries money and provide additional benefits in some cases.

The resource guide may be found at:

http://www.nmep.org/library/smbokit/rg_info/overview.htm

- HCFA also produced an Outreach Kit for the dual eligible population. The Outreach Kit provides actual models that State, tribal, local, religious, and beneficiary groups can modify to conduct their own outreach and enrollment campaigns, with minimal resources. The Outreach Kit includes model elements such as a poster, brochure, educational presentations (overheads and handouts) with speakers' notes, newsletter articles, scripts for public service announcements, beneficiary and intermediary screening tools, a model application and a glossary of terms. The outreach kit may also be found on the above website containing the resource guide.

- HCFA worked with the SSA, HRSA, and American Association of Retired Persons (AARP) to conduct five regional training sessions on dual eligible outreach and enrollment called "Reach Out: Building State and Community Partnerships to Enroll Dual Eligibles." Representatives from the SSA, HCFA, HRSA, community health centers, States, Tribes, SHIPs, and the beneficiary and provider community were invited to the training sessions, providing the opportunity for all stakeholders to work collaboratively on state-specific issues.

- HCFA and the Administration on Developmental Disabilities have contracted with National Association of Protection and Advocacy Services to fund four one-year pilot ombudsman outreach projects with the States of Washington, Michigan, Georgia and New York. The Association will focus on one-on-one consumer assistance, including outreach, pre-screening, and enrollment navigational assistance for potential dual eligible beneficiaries.

- HCFA worked with SSA on the design of their demonstration which test various levels of additional SSA participation in the enrollment process for dual eligibles. The project was implemented in seven states, beginning in March 1999.

- HCFA is currently pursuing several projects designed to enhance SHIP outreach to the dual eligible population. The projects include:

- A project to research effective SHIP outreach practices for dual eligibles. The goal is to raise awareness of dual eligible programs and to assist the SHIPs with their dual eligible outreach efforts. The final product will be an "Effective Practices Outreach Kit" that highlights effective and practical SHIP outreach practices to dual eligibles that may be duplicated in different SHIP environments. This outreach kit will include sample handouts and materials that could easily be used and tailored by SHIPS.

- Another project developed a competitive supplemental grant solicitation process to support new projects on enrollment promotion. The purpose of these grants is to stimulate and fund innovation SHIP projects aimed at increasing enrollment in dual eligible programs.

- A comprehensive training manual for SHIPs was developed to assure that they have the most current information on the dual eligible programs and proper training on counseling techniques for these programs.

Module VI Overview

Changing demographics and health care structures as well as mandates from consumers and health care authorities make cultural competency a need for SHIP counselors. This module will address the issues associated with cultural sensitivity and disability sensitivity. A video accompanies this module to provide participants with specific role plays showing methods to counsel potential dual eligibles of differing backgrounds. The goal of Module Six is to raise counselor's awareness of cultural issues and the need to take differences into account when helping individuals from different backgrounds.

Keep in mind that in addition to differences between groups,
there are also differences among individuals within the same group.

Keep in mind that making assumptions on ethnic background
or disabilities is a mistake.

Learning Objectives

At the conclusion of this module, you will:

- Recognize the need for culturally competent counseling.
- Recognize the need for disability sensitivity.
- Learn about different techniques for counseling diverse populations.

What is Cultural Competency?

- Cultural competency[1,2] is the ability of you and your organization to respond respectfully and effectively to people of all cultures.

- Culturally competent interactions provide positive reinforcement of the value and richness of diverse cultures and preserve the dignity of individuals, families and communities.

- Cultural competency is a set of behaviors, attitudes and policies that together enable individuals and organizations to work effectively in cross–cultural situations.

- Cultural competence requires organizations to transform knowledge about individuals and groups of people into specific standards, policies, practices and attitudes to increase the quality of service to diverse groups, thereby producing better outcomes.

- A group's culture reflects the learned and shared knowledge, beliefs and rules that people use to interpret experience and to generate social behavior. It is the guiding force behind the behaviors associated with a group of people.

- The word competence is used because it implies not just knowing about the beliefs and values if different cultures but being able to apply that knowledge in real world settings.

Being competent in cross–cultural functioning means learning new patterns of behavior and effectively applying them in the appropriate settings.[3]

[1]Cross T., Bazron, B., Dennis, K., and Isaacs, M. (1989). Towards a culturally competent system of care, Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
[2]Isaacs, M. and Benjamin, M. (1991). Towards a culturally competent system of care, Volume II. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
[3]Davis, K. (1997). Exploring the intersection between cultural competency and managed behavioral health care policy: Implications for state and county mental health agencies. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

Things to Think About for Cultural Competency[4]

- Cultural competency should be viewed as a process of continually refining, expanding and updating one's understanding of different cultures.

- Cultural identification does not necessarily mean that an individual subscribes to all of the beliefs dominant in that culture.

- Cultural diversity must be understood to mean differences both among and within cultures.

- Culture, race and ethnicity are not interchangeable. For example, many different cultures exist among persons of the same race, persons who share ethnicity may not be of the same race and persons of different races may share cultural ideology.

- Culture affects a counselor's expectations, attitudes, and behavior as much as those of clients and can be a barrier to customer service or successful counseling.

- Cultural "difference" is not characteristic of one group but a relational quality between and among groups.

- Economic stresses related to minority status, such as inadequate housing, illiteracy combined with misunderstanding language of US health care system, and lack of translated materials on health care, are frequently related to social and economic factors, not cultural ones.

- Immigrant clients may be struggling with issues of immigration and the stresses of adapting to a new environment where loss of family, neighborhood, and homeland, along with changes in culture and language, can be traumatic and invoke illness.

[4] Davis, K. (1997). Exploring the intersection between cultural competency and managed behavioral health care policy: Implications for state and county mental health agencies. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

To Obtain Additional Information on Cultural Competency

There are a number of organizations and websites devoted to the advancement of cultural competency in health care, which can provide more information on issues surrounding cultural competency and also serve as a resource for more specific questions you might have.

The Health Resources and Services Administration (HRSA) provides leadership for programs and activities that address the special health needs of racial/ethnic minorities to eliminate disparities, while improving health status.

Contact Information:
Health Resources and Services Administration (HRSA)
Office of Minority Health
http://www.hrsa.dhhs.gov/hrsa/omh/omh.htm

The Office of Minority Health has a goal of promoting improved health among American Indian and Alaska Native, African American, Asian American and Pacific Islander, and Hispanic populations.

Contact Information:
Office of Minority Health
http://www.omhrc.gov/AboutOMH.HTM

Bureau of Primary Health Care's Cultural Competency Program includes guidelines to help assess cultural competence in program design, application, and management.

Contact Information:
Bureau of Primary Health Care's Cultural Competency Program
http://158.72.105.163/cc/default.htm

Center for Effective Collaboration and Practice includes descriptions of what other organizations are doing to address issues of cultural competence.

Contact Information:
Center for Effective Collaboration and Practice
http://www.air.org/cecp/cultural

Diversity Rx is an Internet-based clearinghouse of information on how to meet the language and cultural needs of minorities, immigrants, refugees and other diverse populations seeking health care.

Contact Information:
Diversity Rx
http://www.diversityrx.org

Foundation for Better Health Care provides a closer look at cultural competency and how you can measure your own progress in serving ethnically and culturally diverse patients.

Contact Information:
Foundation for Better Health Care
http://fbhc.org/professionals/culturalcomp/home.html

Please elaborate in the box below on the specifics (including contact information) of your local contacts.

Disability Sensitivity

According to the U.S. Census Bureau's 1994-95 data approximately 72.2 percent of African-Americans with disabilities and 51.9 percent of Hispanics with disabilities are not working. The data further shows that 85.5 percent of African Americans and 75.4 percent of Hispanics with severe disabilities are not working. Individuals with disabilities who are members of other minority groups are also disproportionately represented among the unemployed. The major barriers to achievement by people with disabilities in our society continue to be attitudinal barriers, stereotypical thinking and assumptions about what people can and cannot do.[5]

Attitudinal Barriers

- Pity

  People feel sorry for the person with a disability, which tends to lead to patronizing attitudes. People with disabilities generally do not want pity and charity, just equal opportunity to earn their own way and live independently.

- Hero worship

  Most people with disabilities do not want accolades for performing day-to-day tasks. The disability is there; the individual has simply learned to adapt by using his or her skill and knowledge, just as everybody adapts to being tall, short, strong, fast, easy-going, bald or blonde.

- Ignorance

  People with disabilities are often dismissed as incapable of accomplishing a task without the opportunity to display their skills. In fact, people with quadriplegia can drive cars and have children. People who are blind can tell time on a watch and visit museums. People who are deaf can play baseball and enjoy music. People with developmental disabilities can be creative and maintain a strong work ethic.

[5]President's Committee on Employment of People with Disabilities.

- Spread Effect

  People assume that an individual's disability negatively affects other senses, abilities or personality traits, or that the total person is impaired. For example, many people shout at people who are blind or do not expect people using wheelchairs to have the intelligence to speak for themselves. Focusing on the person's abilities rather than his or her disability counters this type of prejudice.

- Stereotypes

  The other side of the spread effect is the positive and negative generalizations people form about disabilities. For example, many believe that all people who are blind are great musicians or have a keener sense of smell and hearing; that all people who use wheelchairs are docile and compete in special athletic events; that all people with developmental disabilities are innocent and sweet-natured; and that all people with disabilities are sad and bitter. Aside from diminishing the individual and his or her abilities, such prejudice can set too high or too low a standard for individuals who are merely human.

- Fear

  Many people are afraid that they will do or say the wrong thing around someone with a disability. They therefore avert their own discomfort by avoiding the individual with a disability. As with meeting a person from a different culture, frequent encounters can raise the comfort level.

Actions to Overcome Disability Barriers[6]

- Take the time to learn more about the hopes, fears and aspirations of persons with disabilities in your community.

- Listen to the person with the disability. Do not make assumptions about what that person can or can not do.

- When speaking with a person with a disability, talk directly to that person, not through his or her companion. Maintain eye contact. This point applies whether the person has a mobility impairment, a mental impairment, is blind or is deaf and uses an interpreter.

- Extend common courtesies to people with disabilities as you would anyone else. Shake hands or hand over business cards. If the person cannot shake your hand or grasp your card, they will tell you. Do not be ashamed of your attempt, however.

- If the customer has a speech impediment and you are having trouble understanding what he or she is saying, ask the person to repeat rather than pretend you understand. The former is respectful and leads to accurate communication; the latter is belittling and leads to embarrassment.

- Offer assistance to a person with a disability, but wait until your offer is accepted before you help.

- It is okay to feel nervous or uncomfortable around people with disabilities, and it is okay to admit that feeling. It is human to feel that way at first. When you encounter these situations, think "person" first instead of disability; you will eventually relax.

[6] President's Committee on Employment of People with Disabilities.

To Obtain Additional Disability Information

The Americans with Disability Act (ADA) Information Center for the Mid-Atlantic Region is one of ten regional centers established to provide training, information and technical assistance on the ADA to businesses, consumers and the state and local governments.

The Disability and Business Technical Assistance Centers (DBTAC) facility has a toll-free hotline staffed by specialists who can answer specific questions on the ADA. Callers also may order materials from the Center's library of ADA and disability-related publications. Provided free or at cost, these materials include the full regulations, technical assistance manuals, architectural guidelines, easy-to-read fact sheets and summaries, suggestions on how to make different types of businesses accessible to the public, and consultation on employment issues, such as reasonable accommodations. All materials are available in alternate formats such as large print, Braille, tape and computer disk. There are some materials in Spanish.

The ADA Information Center also works with its local affiliates in Pennsylvania, Delaware, Maryland, West Virginia, the District of Columbia, and Virginia to provide free or low-cost training programs to help employers, agencies, people with disabilities and businesses to understand and comply with the law. A training or presentation can be tailored to the interests of the audience, and can be a simple overview or in-depth review of a particular area of the law

Contact Information:
Disability and Business Technical Assistance Centers
451 Hungerford Drive, Suite 607
Rockville, MD 20850-4151
Voice: (301) 217-0124
TTY/TDD/VOICE: (800) 949-4232
Fax: (703) 525-6835
E-Mail: adainfo@transcen.org
Internet: http://www.againfo.org

The Howard University Research and Training Center provides research, technical assistance, and training to persons with disabilities and their families for both pre-service and in-service activities.

Contact Information:
Howard University Research and Training Center
2900 Van Ness Street, NW
Washington, DC 20008
Voice: (202) 806-8086
TDD: (202) 224-7628
Fax: (202) 376-6219

The Job Accommodation Network (JAN) is not a job placement service, but an international toll-free consulting service that provides information about job accommodations and the employability of people with disabilities. JAN also provides information regarding the Americans with Disabilities Act (ADA).

Contact Information:
President's Committee on Employment of People
with Disabilities' Job Accommodation Network (JAN)
West Virginia University
P.O. Box 6080
Morgantown, WV 26506-6080
VOICE/TTY/TDD: (800) 526-7234
Fax: (304) 293-5407
E-Mail: jan@jan.icdi.wvu.edu
Internet: http://janweb.icdi.wvu.edu

The President's Committee is a small federal agency whose Chairman and Vice Chairs are appointed by the President. The Chairman appoints the other Executive Board members and members of the six standing subcommittees. Directed by the Chairman and Executive Board, the Committee achieves its goals through the work of its subcommittee members and 37-member agency staff, in close cooperation with the Governor's Committees in the states, Puerto Rico and Guam and with Mayor's Committees throughout the United States.

The President's Committee on Employment of People with Disabilities' mission is to communicate, coordinate and promote public and private efforts to enhance the employment of people with disabilities. The Committee provides information, training, and technical assistance to America's business leaders, organized labor, rehabilitation and service providers, advocacy organizations, families and individuals with disabilities. The President's Committee reports to the President on the progress and problems of maximizing employment opportunities for people with disabilities.

Contact Information:
President's Committee on Employment of People with Disabilities
1331 F Street, NW
Washington, DC 20004-1107
Voice: (202) 376-6200
TTY/TDD: (202) 376-6219
Fax: (202) 376-6205
E-Mail: info@pcepd.gov
Internet: http://www50.pcepd.gov/pcepd

Please elaborate in the box below on the specifics (including contact information) of your local contacts.

Summary of Module

In this module you learned:

- The importance of cultural competency.
- Tips to overcome actions and behaviors that are barriers in relating to persons with disabilities.
- Suggestions for counseling potential dual eligibles from multicultural groups and individuals with disabilities.

Technical Appendix

There are five essential elements that contribute to a service delivery system's ability to become more culturally competent.

The system should:

- Have the capacity for cultural self–assessment
- Value diversity
- Be conscious of the "dynamics" inherent when cultures interact
- Institutionalize cultural knowledge, and
- Develop adaptations to service delivery reflecting an understanding of diversity between and within cultures.

Further, these five elements must be manifested in every level of the service delivery system. They should be reflected in attitudes, structures, policies and services.[7]

[7] "Perspectives of Difference", Division of General Internal Medicine, University of California San Francisco.

Indicators of Cultural Competence
Honoring the racial, cultural, ethnic, religious and social and economic diversity of families.[8]

- Recognizing the power and influence of culture
- Understanding how your own background affects your response to others
- Not assuming that all members of a cultural group have the same beliefs and practices
- Approaching each family with no preconceptions
- Helping families learn how to use and influence the system developed by the mainstream culture
- Acknowledge how past experiences with racism affect present interactions
- Actively eliminate racism in policies and practices
- Building on the strengths and resources of each child, family, community and neighborhood

[8]The National Maternal and Child Health Resource Center on Cultural Competency for Children with Special Health-Care Needs and Their Families.