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DEPARTMENT OF HEALTH

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TRANSMITTAL: 11 OHIP/ADM-2

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: March 11, 2011

SUBJECT: Automated Enrollment into the Medicare Savings Program in Upstate New York under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

SUGGESTED DISTRIBUTION:	Local District Commissioners Medicaid Staff Temporary Assistance Staff Staff Development Coordinators Fair Hearing Staff
CONTACT PERSON:	Local District Liaison: Upstate: (518)474-8887 New York City: (212)417-4500
ATTACHMENTS:	Attachment I - DOH-4496, Medicare Savings Program Request for Information Attachment II - OHIP-0037, Option to Receive Medicare Savings Program (MSP) Benefit Attachment III - OHIP-0026, Explanation of the Excess Income Program Attachment IV - OHIP-0035, Request for Information Cover Letter Attachment V - OHIP-0014, Notice of Transition of Your MA/FHP/FHP-PAP/FPBP and/or MSP Coverage (County A) Attachment VI – OHIP-0015, Notice of Transition of Your MA/FHP/FHP-PAP/FPBP and/or MSP Coverage (County B) Attachment VII – OHIP-0051, Notice of Medicare Savings Program Case Opened in Error

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
10 OHIP/ADM-3 08 OHIP/ADM-4 05 OMM/ADM-5 10 OHIP/INF-3			Sec. 1144. [42 U.S.C. 1320b-14]of the Social Security Act PL 110-275, Section 113		08 OHIP/LCM-1 GIS 05 MA/024 GIS 04 MA/013

I. Purpose

The purpose of this Office of Health Insurance Programs Administrative Directive (OHIP/ADM) is to advise local departments of social services (LDSS) of changes to the implementation of Section 113 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which requires applications for the federal Low Income Subsidy program to be considered an application for the Medicare Savings Program (MSP).

II. BACKGROUND

The Low Income Subsidy (also known as "Extra Help") is a Medicare benefit program administered by the Social Security Administration (SSA) to help low income Medicare beneficiaries pay for prescription drug costs associated with their Medicare Part D benefits. The Medicare Savings Program is a Medicaid benefit that helps Medicare beneficiaries pay for costs associated with Medicare Part A and Part B. As part of an effort to decrease barriers to enrollment, Section 113 of the MIPPA states that an application to SSA for the Low Income Subsidy (LIS) program for Medicare Part D benefits will also be used to initiate an application for benefits under the Medicare Savings Program. This statutory requirement is intended to improve enrollment in both the Medicare Part D Low Income Subsidy program, administered by the Social Security Administration, and the Medicare Savings Program, administered by the states.

III. PROGRAM IMPLICATIONS

Beginning January 1, 2010, with the consent of the applicant, SSA began transmitting data received from the LIS "Extra Help" application to the State for consideration of the applicant's eligibility for the Medicare Savings Program. The State receives this information via an electronic file from SSA each day that SSA makes LIS eligibility determinations. This data must be treated as if the individual had applied for the MSP directly to the Medicaid program.

To minimize the workload this increase in MSP applications has created for local departments of social services, the New York State Department of Health (NYSDOH) is automating as much of the application process as possible. By automating this process, the LDSS are relieved of the responsibility for review and determination of benefits for the majority of MSP applications received from SSA.

Upon receipt of the file from SSA, each application will be matched against the Welfare Management System (WMS). If a Client Identification Number (CIN) exists in WMS for the individual, it will be used to register the application, barring certain circumstances. When a match in WMS is not found, a CIN will be generated for the applicant. Once the application is registered, it will be automatically accepted or denied, or listed on an Exception Report for manual processing.

A. Applications Accepted through the Automated Process

Eligible applications from SSA indicating a net income level below 135% of the current Federal Poverty Level (FPL) will trigger an automatic opening of a MSP case by the State, using new opening codes created for this purpose. (Refer to Section VI.) Cases will be authorized based upon the date of application to SSA, not the date the application is received by the State.

The net income level indicated on the SSA file will be compared to the current Federal Poverty Levels to determine the applicant's MSP category: Qualified Medicare Beneficiary (QMB) 100% FPL; Specified Low Income Medicare Beneficiary (SLIMB) 120% FPL; or Qualifying Individual (QI) 135% FPL. Income information will not be stored on the Medicaid Budget Logic (MBL) system.

Note: LIS application data sent by SSA to the State has been verified by SSA and is sufficient for documentation of identity, income, residence and citizenship.

Individuals determined eligible for MSP benefits based on the income information received from SSA will be sent an acceptance notice by the State through the Client Notice System (CNS). The notice will inform the individual of their MSP category. The acceptance notice will include the revised "Medicare Savings Program Request for Information" form (Attachment I), which is designed to collect additional demographic and financial information not collected on the LIS application, or for the recipient to report a change in circumstances.

The "Medicare Savings Program Request for Information" form may be completed by the MSP recipient and returned to the local district. Recipients may use this form to request consideration for retroactive MSP coverage, if applicable, to provide information about other health insurance premiums paid, or to report income information. The recipient will be instructed to return the form to his or her LDSS office, and the LDSS will be responsible for acting on information received on this form in a timely manner. Returning the "Medicare Savings Program Request for Information" form is optional for cases that were opened through the automated process. If the individual does not return the form, they will continue to receive the benefit indicated on their acceptance notice.

Additional financial information provided by the recipient may affect the MSP level of benefits the individual is entitled to receive. If the income reported on the "Medicare Savings Program Request for Information" form supports a different MSP category than the MSP category determined through the automated process, verification of income must be provided prior to changing the MSP level. When a change in MSP category is indicated, the LDSS district must change the MSP code in WMS and in eMedNY and send the appropriate undercare notice.

Recipients may indicate on the returned "Medicare Savings Program Request for Information" form that they are paying health insurance premiums other than Medicare. Health insurance premiums other than Medicare Part B are an allowable income deduction for MSP cases; however, SSA does not collect this information on the LIS application. If the individual indicates and provides proof that they pay such premiums, an MBL budget must be calculated to determine if a change in MSP category is appropriate. If a change in category is indicated, the district must process the change and send the appropriate notice.

Recipients may use the "Medicare Savings Program Request for Information" form to request retroactive MSP benefits. The policy for retroactive MSP benefits has not changed. Individuals eligible for QMB are not entitled to retroactive benefits. Recipients eligible for SLIMB and QI may be entitled to retroactive benefits for three months prior to the date of the LIS application if they are otherwise eligible. Retroactive QI benefits may not be provided for a previous calendar year.

Recipients may indicate on the "Medicare Savings Program Request for Information" form that they would like to apply for full Medicaid benefits. In this case, the local district must send the Access NY Health Care application and Supplement A, if applicable, to the MSP recipient. The recipient must complete the application and comply with all current procedures for applying for Medicaid benefits.

New QMB, SLIMB and QI cases should be selected for annual renewal according to the current renewal process. QI cases will be authorized through 12/31/2049, as they are currently.

Automated eMedNY Implications

The State will enter all necessary transactions in eMedNY to create Medicare coverage and Buy-In date spans for applications accepted through the automated process. For all MSP categories, the "Begin Date" for Medicare Part A and Part B coverage will be the first day of the month of application to SSA for LIS. The Medicare coverage "Begin Date" can be updated by the LDSS if retroactive benefits are authorized.

For individuals found eligible for SLIMB and QI benefits, the MSP Buy-In "Begin Date" will be the first day of the month of application to SSA for LIS. For those found eligible for QMB benefits, the MSP Buy-In "Begin Date" will be the first day of the month following the month of application to SSA for LIS. Buy-In date spans in eMedNY will be generated by the State and can be identified by the Transaction Source Code of "5" (NYSDOH) on the Third Party Resource page.

Through the automated process a non-photo Common Benefit Identification Card (CBIC) will be issued based on the default card code of "N" on screen 5 in WMS to all applicants determined to be eligible for QMB benefits. SLIMB and QI cases will default to a card code of "X" and a CBIC will not be issued. LDSS-3209, "Application Turnaround Document (APTAD)," will be created for any cases opened through the automated process.

B. Applications Denied through the Automated Process

Some applications transmitted to the State from SSA for MSP benefits will be denied through the automated process. Applications denied using the automated process will include individuals who are:

- FPL; or reported on the SSA file as having income in excess of 135% of the
- denied by SSA as not in receipt of Medicare.

These applicants will be sent a denial notice by the State through CNS which will include contact information for the appropriate local district. If the applicant is denied MSP benefits for excess income, the denial notice will indicate the net income derived from the percentage of the Federal Poverty Level for the applicant as reported on the SSA file, and compare this amount to the highest income level for the Medicaid Savings Program, which is 135% of the FPL. The notice will also state that the applicant may request a Fair Hearing if he or she disagrees with the decision made by the State. (Refer to Section V. for information about Fair Hearings.)

IV. REQUIRED ACTION

Each local district will receive a daily Benefits Issuance and Control System (BICS) report, WINR5531, of MSP applications received from SSA. The report will include name, Client Identification Number (CIN) and case number for each application, date of application for LIS, and will indicate whether the application was automatically accepted, denied, or exceptioned for manual review by the district. An MSP application will not be registered if the applicant already has an active Medicaid and/or MSP case. (See Section IV.A.1.)

Case numbers assigned through the automated process will contain a unique identifier to distinguish them from cases derived through other sources and will begin with the letters “LI”. The case number format will be LIYYDDD999, where YY is year, DDD is Julian day, and 999 is sequence number. The “Office” will be identified as “LIS”, the “Unit” will be “MSP”, and the “Worker” will be “NYSSA”. The application will remain in “Pend” status for three business days. While the application is in “Pend” status, the LDSS may change the case number, office, unit, or worker but cannot cancel the case.

A. Applications Exceptioned

Some applications transmitted to the State from SSA will require manual review and determination of benefits by the local district. These applications and the reason for the exception will appear on the BICS WINR5531 report sent to each local district. All exceptioned applications appearing on the WINR5531 report must be reviewed for MSP eligibility. The LDSS must send the appropriate MSP acceptance or a denial notice using current CNS notices once a determination of benefits is completed.

1. Types of Exceptioned Applications Requiring Manual Processing

a. Individuals already in receipt of MSP (MSPI Value present)

For individuals who are already in receipt of MSP benefits, no action is required to be taken.

b. Individuals already in receipt of Medicaid without MSP

For individuals who are in receipt of Medicaid, but not in receipt of MSP benefits, districts must review the information in the current case record to ascertain whether the applicant should have been determined eligible for MSP. If found eligible, the district must accrete the individual to the Medicare Savings Program and send the appropriate notice. (Refer to Section IV.A.2. of this ADM.) If after reviewing the case, the individual is determined to be ineligible for MSP, the LDSS must deny MSP benefits to the individual and send the appropriate notice. The current Medicaid case would remain unchanged.

Some individuals who are in receipt of Medicaid may be using their Medicare premium as a deduction from income in order to qualify for full Medicaid or to reduce their spenddown obligation under the Excess Income Program. In either case, the LDSS must offer these individuals the choice to either participate in the Medicare Savings Program or to continue using their Medicare premium to qualify for Medicaid. This choice must be offered even if the individual has previously stated his or her selection. Attached is OHIP-0037, “Option to Receive Medicare Savings Program (MSP) Benefit” (Attachment II), that must be sent to these individuals allowing them to indicate their choice. This form should be sent with OHIP-0026, “Explanation of the Excess Income Program” (Attachment III).

If the individual does not return the completed form, the Medicaid case would remain unchanged and no further action would be required. If the recipient returns the form and requests payment of Part B premiums, the district must recalculate Medicaid eligibility, accrete the individual to the Medicare Savings Program and send the appropriate MSP acceptance notice and change in eligibility notice. (Refer to Section IV.A.2. of this ADM.)

c. Individuals with an “M” suffix on the Health Insurance Claim Number (HICN)

Most individuals who are eligible for Medicare Part B are also eligible for premium free Part A coverage. However, some individuals who are eligible for Medicare Part B do not have credit for sufficient work quarters to qualify for free Medicare Part A. An “M” suffix on the HICN indicates an individual does not have sufficient work credit for premium free Medicare Part A.

Some individuals are eligible for Medicaid payment of their Medicare Part A premium through the Part A Buy-In program. Refer to GIS 04 MA/013 for more information on Medicare Part A Buy-In procedures.

If an active case exists for the individual, LDSS must review the file to determine whether the applicant is eligible for the Part A Buy-In program. If the individual qualifies for payment of their Medicare Part A premium through the Part A Buy-In program, a QMB case should be opened and an acceptance notice sent using Reason Code X54, Accept Medicare Buy-In Program (QMB). If the applicant is not eligible for payment of their Part A premium, the application for MSP benefits should be denied and a notice sent using Reason Code X52, Deny Medicare Buy-In Program (QMB). The current Medicaid case would remain unchanged.

If this is a new applicant, LDSS staff must mail the "Medicare Savings Program Request for Information" form (Attachment I) with the "Request for Information Cover Letter" (Attachment IV) to the individual. If the applicant does not return the completed form, LDSS must send manual denial notice OHIP-0036, "Notice of Denial for Medicare Savings Program (Application Received from SSA)."

d. Applications with blank income fields on the SSA file

For new applicants whose income information on the SSA file is blank (income field is not completed), the LDSS must obtain from the applicant the information necessary to process the application. The LDSS must send DOH-4496, "Medicare Savings Program Request for Information" (Attachment I) with the "Request for Information Cover Letter" (Attachment IV) to obtain income information and verification necessary to process the application. Once the district obtains the necessary income information, a MBL budget must be created. An acceptance or a denial notice must be sent using current CNS notices once a determination of benefits is completed. Applicants who do not return the form must be sent manual denial notice OHIP-0036, "Notice of Denial for Medicare Savings Program (Application Received from SSA)."

Applicants who indicate they have no income ($0 reported on the SSA file) will not appear on the daily BICS WINR5531 report. These applications will be processed automatically since income information was provided by the individual and verified by SSA.

2. Manual eMedNY Implications

The LDSS is responsible for processing all MSP applications accepted following manual review and for any requests for retroactive coverage. The LDSS is also responsible for the manual review and determination of benefits for applications appearing as exceptioned on the WINR5531 report.

a. The LDSS must enter all necessary information in the eMedNY Buy-In screens, including the appropriate MSP code used to indicate the category of MSP awarded: QMB, SLIMB or QI.

b. For all MSP categories, the "Begin Dates" for Medicare Part A and Part B coverage are to be entered as the first day of the month of application for LIS, unless the district has obtained more accurate information from the applicant, or if the applicant has been determined eligible for retroactive payment of premiums.

c. For individuals found eligible for SLIMB and QI, the MSP Buy-In "Begin Date" is equal to the first day of the month of application to SSA for LIS, unless the applicant is determined eligible for retroactive payment of premiums. For those found eligible for QMB, the MSP Buy-In "Begin Date" is equal to the first day of the month following the month of application for LIS. A Common Benefit Identification Card must be issued to all QMB recipients.

d. For individuals found eligible for QMB, a card code of "N" must be entered so these recipients will receive a non-photo CBIC. For those determined to be eligible for SLIMB and QI, a card code of "X" must be entered so a CBIC is not issued.

The application date for new MSP applications sent to the State by SSA is equal to the date the individual applied for LIS benefits at SSA. This date is reflected on screen 1 of WMS as the "Application Date." The date an eligibility determination is performed is reflected on screen 1 of WMS as the "Transaction Date."

Note: The LDSS must determine eligibility for all applications on the Exception Report promptly, generally within 45 days of the date that the district receives the information from the State. Under certain circumstances, additional time for determination of eligibility may be required, such as in the case of a delay on the part of the applicant, or in the case of an administrative or other emergency that could not be controlled by the district.

B. Cases Incorrectly Assigned to a District

If the LDSS identifies a case opened through the automated process that was assigned to the district incorrectly, the district must transfer the case to the appropriate district in accordance with current protocols. In this situation, the assigned district must contact the correct district to obtain its agreement to transfer the case and coordinate closing the incorrectly assigned case with the opening of a new case in the correct district.

This process must take place in a manner that allows coverage to continue without interruption, and the manual notice OHIP-0014, "Notice of Transition of Your Medicaid/Family Health Plus/Family Health Plus-Premium Assistance Program/Family Planning Benefit Program and/or Medicare Savings Program Coverage (County A)," must

be sent to the recipient (Attachment V). If the assigned district does not obtain agreement from the other district to open the case, the assigned district must maintain the opened case until the district of fiscal responsibility is determined through a Fair Hearing. Once a case is successfully transferred to the correct district, the new district must send manual notice OHIP-0015, "Notice of Transition of Your Medicaid/Family Health Plus/Family Health Plus-Premium Assistance Program/Family Planning Benefit Program and/or Medicare Savings Program Coverage (County B)" (Attachment VI) to the recipient.

C. Duplicate Cases

There may be instances when the automated process does not recognize an existing CIN in WMS for an individual whose application appears on the SSA file. A new case may be registered with a new CIN for an individual.

1. Original Case is Active

In the event that the LDSS discovers that a duplicate case/CIN was opened through the automated process, the LDSS must consolidate cases/CINs.

- Close the newly created case.
- Close the Medicare Buy-In span established by the automated process.
- Consolidate the CINs assigned to the individual.
- Retain the CIN of the original case.
- Delete the newly created CIN.

A new manual notice, OHIP-0051, "Notice of Medicare Savings Program Case Opened in Error" (Attachment VII) informs the recipient that a duplicate case was opened in error through the automated process. The notice also advises whether the individual will receive MSP benefits under the original Client Identification Number. In addition, districts must take the following actions, depending upon the benefits the individual is currently receiving.

a. For active cases with MSP only or active Medicaid with MSP, and a duplicate case is opened for MSP:

- Send OHIP-0051, "Notice of Medicare Savings Program Case Opened in Error" (Attachment VII). Enter the effective date, name and CIN for the discontinued case.
  - o Check the first box indicating the CIN under which the individual will continue to receive MSP benefits. Enter the CIN for the retained case.
- If a CBIC was issued for the duplicate case, the bottom section of the notice must be completed.
  - o If the duplicate case was for QMB, check the box saying the discontinued CBIC will no longer work, and enter the CIN found on that card.

- If the recipient was issued a card on the original case, check the box instructing the recipient to keep the original card, and enter the CIN for that card.

b. For active Medicaid only cases (no spenddown) without MSP benefits, and a duplicate case is opened for MSP, review the existing case for MSP eligibility.

- If MSP eligible:
  - Enter the MSP code in WMS under the retained CIN.
  - Create a Buy-In span in eMedNY for MSP under the retained case.
  - Send OHIP-0051, "Notice of Medicare Savings Program Case Opened in Error." Enter the effective date, name and CIN for the discontinued case.
  - The recipient will receive MSP benefits under the retained CIN.
    - Check the first box indicating the CIN under which the individual will receive benefits. Enter the CIN for the retained case.
  - If a CBIC was issued for the duplicate case, the bottom section of the notice must be completed.
    - If the duplicate case is for QMB, check the box saying the discontinued card will no longer work, and enter the CIN found on that card.
    - If the recipient was issued a card on the original case, check the box instructing the individual to keep the original benefit card, and enter the CIN for that card.

- If not MSP eligible:
  - Send OHIP-0051, "Notice of Medicare Savings Program Case Opened in Error." Enter the effective date, name and CIN for the discontinued case.
    - Check the second box stating the individual will continue to receive Medicaid under the retained CIN and enter the CIN for that case.
    - Check the first indented box and enter the net income and MSP limit of 135% FPL.
  - If a CBIC was issued for the duplicate case, the bottom section of the notice must be completed.
    - If the duplicate case was for QMB, check the box saying the discontinued CIBC will no longer work, and enter the CIN found on that card.
    - If the recipient was issued a card on the original case, check the box instructing the individual to keep the original benefit card, and enter the CIN for that card.
  - The original Medicaid case will remain unchanged.

c. For active Medicaid cases having a spenddown:

- Send OHIP-0051, "Notice of Medicare Savings Program Case Opened in Error." Enter the effective date, name and CIN for the discontinued case.

- Check the second box stating the individual will continue to receive Medicaid under the retained CIN and enter the CIN for that case.
- Check the second indented box indicating the option to choose to participate in the Excess Income Program or MSP.

- If a CBIC was issued for the duplicate case, the bottom section of the notice must be completed.
  - If the duplicate case was for QMB, check the box saying the discontinued CBIC will no longer work, and enter the CIN found on that card.
  - If the client was issued a CBIC on the original case, check the box instructing them to keep the original CBIC, and enter the CIN for that card.
- Send OHIP-0037, "Option to Receive Medicare Savings Program (MSP) Benefit."
- Send OHIP-0026, "Explanation of the Excess Income Program."
- If OHIP-0037 is returned, make all necessary adjustments to the case and send the appropriate notice to the individual.
- If the individual does **not** return OHIP-0037, the original (retained) Medicaid case will remain unchanged.

d. For active Medicaid only cases in WMS, and the MSP application on the SSA file is denied using a duplicate CIN:

- Send OHIP-0051, "Notice of Medicare Savings Program Case Opened in Error."
- The recipient will continue to receive Medicaid under the retained CIN.
  - Check the second box stating the individual will continue to receive Medicaid under the retained CIN and enter the CIN for that case.

e. For active cases with MSP only or active Medicaid with MSP, and the MSP application on the SSA file is denied using a duplicate CIN:

- The recipient will continue to receive benefits under the retained CIN.
- Check the first box indicating the CIN under which the individual will continue to receive MSP benefits. Enter the CIN for the retained case.
- If the individual is also in receipt of Medicaid coverage, check the box indicating the CIN under which the individual will continue to receive Medicaid coverage.

2. Original Case is Closed

The LDSS must consolidate cases/CINs when it discovers that a duplicate case/CIN was created through the automated process and the original case is closed.

- Consolidate the CINs assigned to the individual.
- Retain the CIN of the original case.
- Delete the newly created CIN.

a. For closed cases and the MSP application on the SSA file is denied using a duplicate CIN, no further actions are required to be taken.

b. For closed cases and the MSP application on the SSA file is opened using a duplicate CIN, districts must also take the following actions:

- Reopen the original case.
- Transfer the MSP data to the original case in WMS and eMedNY.
- Enter the MSP indicator on Screen 3.
- Create a Buy-In transaction in eMedNY.
- Send OHIP-0051, "Notice of Medicare Savings Program Case Opened in Error." Enter the effective date, name and CIN for the discontinued case.
- The recipient will receive MSP benefits under the retained CIN.
  - Check the first box indicating the CIN under which the individual will receive benefits. Enter CIN for the retained case.
- If a CBIC was issued with the duplicate CIN, the bottom section of the notice must be completed.
  - If the duplicate case was for QMB, check the box saying the discontinued CBIC will no longer work, and enter the CIN found on that card.
  - If the new case is for QMB, the client will be issued a CBIC with their original CIN. Check the box instructing them to keep that CBIC, and enter the CIN for that card.

V. FAIR HEARINGS

The LDSS is responsible for Fair Hearings requested on any MSP application received and processed through the SSA file. If an individual requests a Fair Hearing, the district must obtain a copy of the notice sent by CNS. The notices will be available via WEBCOINS/COLD through CentraPort. Since MBL budgets are not produced for cases accepted or denied through the automated process, the district must obtain the information provided on the SSA file. This information may be obtained by contacting the NYSDOH Third Party Liability (TPL) Unit in the Division of Coverage and Enrollment and requesting a "MIPPA Report" for the applicant.

The TPL Unit will provide the district with the application information that was received by SSA and a written affidavit explaining the automated MSP enrollment process for use at the Fair Hearing. The Third Party Liability Unit may be contacted by calling (518)473-5330, or by email at jxm24@health.state.ny.us. Fair Hearing staff are aware of the State's automated procedure for processing these applications.

If a case is remanded to the district for follow-up with the applicant after the hearing, it is not necessary to require the individual to complete an MSP application. The district may ask for verification of the item(s) disputed in the hearing in order to redetermine MSP eligibility.

VI. NOTICE REQUIREMENTS

New Client Notice System (CNS) acceptance and denial notices have been developed to be used for the automated processing of MSP applications received from SSA.

The new acceptance notices include a copy of the DOH-4496, "Medicare Savings Program Request for Information," for applicants/recipients (A/Rs) to use if they wish to submit additional financial or demographic information not collected on the LIS application. The form also allows the A/R to request consideration for retroactive coverage. A/Rs are instructed to return completed forms to the local district office for processing. The LDSS must review and process these forms in a timely manner following established procedures. Returning the "Medicare Savings Program Request for Information" form is voluntary for cases that are opened through the automated process. Failure by the individual to return this form is not grounds for terminating MSP coverage.

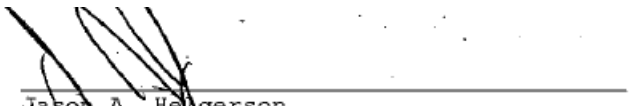
The following new notices and reason codes have been created for applications accepted and denied through the automated process:

Reason Code 892: Accept QMB from LIS Application
Reason Code 893: Accept SLIMB from LIS Application
Reason Code 894: Accept QI from LIS Application
Reason Code 848: Deny MSP from LIS Application Over Income
Reason Code 849: Deny MSP from LIS Application Not Medicare

Existing CNS or manual notices are to be used for cases manually reviewed by the district from the Exception Report.

VII. EFFECTIVE DATE

The effective date of this ADM is February 21, 2011.



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