NEW YORK STATE OF OPPORTUNITY. Department of Health

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TRANSMITTAL: 17 OHIP/ADM-01

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: October 24, 2017

SUBJECT: Medicare Enrollment at Age 65

SUGGESTED DISTRIBUTION:	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 – End Stage Renal Disease (ESRD) Letter Attachment II – OHIP-0112 (You Must Apply for Medicare) Attachment III – Medicare Warning Letter

FILING REFERENCES

Previous Ref. ADMs/INFs	Releases Cancelled	Dept. Regs. Law	Soc. Serv. & Other	Manual Ref	Misc.
13 OHIP/ADM-04 11 OHIP/ADM-09 00 OMM/ADM-7 93 ADM-30 89 ADM-7			366 (2)(b)(1)		September 28, 2017 - WMS/CNS Coordinator Letter GIS 12 MA/022 GIS 04 MA/013

I. PURPOSE

The purpose of this Office of Health Insurance Programs Administrative Directive (OHIP ADM) is to provide local departments of social services (LDSS) with information and guidance regarding the requirement for certain Medicaid applicants/recipients (A/Rs) to apply for Medicare as a condition of Medicaid eligibility.

II. BACKGROUND

Section 366(2)(b)(1) of the Social Services Law requires individuals who are eligible for, or reasonably appear to meet the criteria of eligibility for, benefits under Title XVIII of the Social Security Act (Medicare), to apply for such benefits as a condition of receiving assistance under the Medicaid program. This requirement applies to individuals who are eligible for payment of their premiums either through the Medicare Savings Program or as a fully eligible Medicaid recipient (without deducting the premium payment from income). These Medicaid A/Rs are required to apply for Medicare as these benefits will reduce the costs incurred by the Medicaid program.

Medicare is a federal health insurance program for individuals who are age 65 or older or who are under age 65 and have been receiving benefits from Social Security or the Railroad Retirement Board for 24 months, regardless of income. Individuals with end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS) may also qualify for Medicare. The Centers for Medicare & Medicaid Services (CMS) is the agency that administers, or oversees the Medicare program, but individuals apply for Medicare at the Social Security Administration (SSA).

As indicated on the CMS.gov and SSA.gov websites, Medicare consists of four parts:

- Medicare Part A (Hospital Insurance) - Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. Most individuals do not pay a premium for Part A.

- Medicare Part B (Medical Insurance) - Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services. All individuals pay a monthly premium for Part B.

- Medicare Part C (Medicare Advantage) - A type of Medicare health plan offered by a private company that contracts with Medicare to provide all benefits and services covered under Part A and Part B. There is a monthly premium.

- Medicare Part D (Prescription Drug Coverage) - Part D helps cover the cost of prescription drugs. Private companies, including Medicare Advantage plans, provide the coverage. There is generally a monthly premium.

Some individuals get Medicare automatically and others must sign up for it. In most cases, it depends on whether the individual is receiving Social Security benefits. Individuals receiving Social Security or Railroad Retirement benefits will automatically be enrolled in Medicare Parts A and B when they turn age 65.

Individuals age 65 or over, who are not receiving Social Security retirement benefits or Railroad Retirement benefits, must enroll in Medicare by contacting the Social Security Administration. When an individual turns age 65, the individual becomes eligible for Medicare if he or she:

- receives or qualifies for Social Security retirement benefits or Railroad Retirement benefits; or
- currently resides in the United States and is either a United States citizen or a lawful permanent resident who has lived in the U.S. continuously for five years prior to applying.

An individual is eligible for Medicare Part A, at no cost, at age 65 if:

- the individual receives or qualifies for Social Security benefits or Railroad Retirement benefits; or
- the individual's spouse (living or deceased, including divorced spouses) receives or is eligible to receive Social Security or Railroad Retirement benefits; or
- the individual or individual's spouse worked long enough in a government job through which Medicare taxes were paid for at least 10 years.

Individuals who do not meet any of these requirements, may be able to get Medicare Part A by paying a monthly premium.

Before age 65, an individual is eligible for Medicare Part A at no cost if the individual:

- has been entitled to Social Security disability benefits for 24 months; or
- receives Social Security disability benefits for ALS; or
- has End Stage Renal Disease (ESRD) ***and is:***
    - eligible for or receives monthly benefits under Social Security or the Railroad Retirement system; or
    - worked long enough in a Medicare-covered government job; or
    - is the child or spouse (including a divorced spouse) of a worker (living or deceased) who has worked long enough under Social Security or in a Medicare-covered government job.

Anyone who is eligible for free Medicare Part A can enroll in Medicare Part B by paying a monthly premium. Anyone not eligible for free Part A, can buy Part B, without having to buy Part A, provided they are a U.S. citizen, or a lawful permanent resident who has lived in the U.S. continuously for five years.

Most people who meet the eligibility criteria for Medicare apply for the benefits once eligible. Some individuals may decline Medicare Part B because of the premium cost and may not know that Medicaid can pay the premiums for fully eligible recipients and for individuals who qualify under the Medicare Savings Program. Each year, from January 1 through March 31, there is a Medicare General Enrollment Period (GEP) for Part B. The GEP is for individuals who did not sign up during their initial enrollment period. Individuals who fail to enroll during their initial enrollment period, or refuse automatic enrollment, may only enroll during the GEP. Individuals whose Part B has ended because of non-payment

of premiums or voluntary withdrawal, may reenroll only during the GEP. Medicaid recipients do not have to wait for the GEP to enroll in Medicare. Fully eligible Medicaid recipients and individuals eligible for the Medicare Savings Program may be automatically accreted by the State to the Medicare Buy-in at any time during the year if the individual has established Medicare entitlement with the SSA.

III. PROGRAM IMPLICATIONS

Historically, it has been the responsibility of the local social services district to identify individuals turning age 65 and ensure that they apply for Medicare benefits as a condition of Medicaid eligibility. Some districts accomplish this by utilizing milestone reports to identify individuals turning age 65 and then conducting outreach via phone calls, letters and client notices.

Recent audits by the Department of Health and the Office of the State Comptroller indicate that many individuals who are over age 65 or who have ESRD are not enrolled in Medicare. To facilitate a process for the identification of individuals who are required to apply for Medicare as a condition of Medicaid eligibility, the Department has made enhancements to the Welfare Management System (WMS) to identify individuals turning age 65 who appear to meet the requirements for Medicare and to automate a notice requiring the individuals to submit proof of application for Medicare. If an individual does not provide the required verification by the designated due date, Medicaid coverage will be automatically discontinued following timely notice. Certain recipients will be required to meet this requirement as part of their Medicaid renewal or combined Temporary Assistance (TA)/Medicaid recertification. All new Medicaid only and TA/Medicaid applicants who are age 65 or over, or turning age 65 in the next three months, who appear to meet the requirements for Medicare, will be required to submit proof of application for Medicare as a condition of eligibility for Medicaid. This includes individuals who are age 65 or older who are parents/caretaker relatives in the Modified Adjusted Gross Income (MAGI) category of assistance.

Most individuals (non-caretaker relatives) receiving Medicaid coverage through New York State of Health (NYSOH) are systematically referred to their local district during the month prior to their 65th birthday for an on-going eligibility determination under a non-MAGI category of assistance. These individuals are required to comply with the Medicare application requirement as part of the redetermination of Medicaid eligibility performed at the local district. For parents and caretaker relatives who turn age 65 and remain on NYSOH under a MAGI category of assistance, system changes will be made to require these individuals to apply for Medicare as a condition of on-going Medicaid eligibility. MAGI individuals who do not provide proof of application for Medicare benefits by the designated due date will have their Medicaid coverage discontinued at the end of the month following timely notice. These individuals are not entitled to a continuation of Medicaid coverage under the provisions of continuous coverage. MAGI individuals who remain in Medicaid on NYSOH, and become enrolled in Medicare, are entitled to reimbursement of their Medicare premiums.

A. Individuals Who Must Apply for Medicare

Fully eligible Medicaid A/Rs (with income at or below the applicable income level) and A/Rs with income at or below 120% of the Federal Poverty Level (FPL), who are age 65 or older, or turning age 65 within the next three months, must apply for Medicare as a condition of eligibility for Medicaid. This requirement applies to Medicaid A/Rs and TA/Medicaid A/Rs. Nursing home residents must show proof of Medicare application at the time of application or renewal.

Incarcerated individuals who have Medicaid coverage reinstated prior to release, must prove application for Medicare, if otherwise required, at renewal following release. Similarly, individuals residing in New York State Office of Mental Health (OHM) psychiatric facilities must provide proof of Medicare application at the time of Medicaid renewal following discharge. Parent/caretaker relatives who are eligible for Medicaid under the MAGI category of assistance through the local district, must meet the requirement to apply for Medicare at age 65, or if turning age 65 within the next three months. Parents/caretaker relatives who do not comply with the requirement to apply for Medicare will have their Medicaid coverage discontinued following timely notice. These individuals will not be entitled to any remaining months of Medicaid coverage that would otherwise be available under the continuous coverage provision.

B. Individuals Excluded from the Medicare Requirement

Individuals presumptively eligible, individuals who are not fully eligible for Medicaid and individuals who have income above 120% of the FPL are excluded from the requirement to apply for Medicare as a condition of Medicaid eligibility. Most immigrants and non-citizens are excluded from this requirement. Only lawful permanent residents who have lived in the U.S. continuously for five years must apply for Medicare as a condition of Medicaid eligibility.

C. Documentation Requirements

Medicaid A/Rs can apply for Medicare by calling the SSA at 1-800-772-1213 to apply by phone or to make an appointment at the local SSA office. Individuals may also apply on-line at https://www.ssa.gov/medicare/. Individuals who apply on-line may be re-directed to apply either by phone or in person if it is determined that the person does not have 40 work quarters. Once an application is completed, the SSA will issue an award or denial letter by mail within two weeks. The Medicare card is mailed separately and is usually issued after the award letter is mailed.

If applying on-line, the applicant will receive an on-line confirmation stating that “You have applied for Medicare with the Social Security Administration.” This confirmation may be printed and used as proof of application. The award or denial letter, or the printed on-line confirmation, are all acceptable forms of documentation.

If an A/R, or the A/R’s legal representative, requires additional time to meet the documentation requirement, the district must allow additional time to provide the required documentation if the A/R or the A/R’s representative is acting to meet the documentation requirement. For example, an individual may not have been able to get a phone interview or in-person interview scheduled for three or four weeks.

Districts must allow additional time to comply with the documentation requirement if circumstances warrant an extension.

D. Recipient Education and Outreach

Beginning in January 2018, Medicaid recipients under the age of 65 receiving ESRD services will receive a letter from the Department of Health (Attachment I) explaining that they may be eligible for Medicare, and that they are required to apply for Medicare benefits. However, these individuals will not get an automated WMS closing, nor will the local district initiate a Medicaid case closing for failure to comply. Instead, the Department of Health intends to conduct outreach to Medicaid recipients with ESRD. EMedNY MOBIUS report, TRMP0161 End Stage Renal Disease, will list individuals who have received this letter.

IV. REQUIRED ACTION

The Access NY Health Care application (DOH-4220) is being revised to include information on the requirement to apply for Medicare as a condition of Medicaid eligibility. Until the revised DOH-4220 is available, an insert to the application (OHIP-0112, Attachment II), explaining the requirement to apply for Medicare, must be included with all applications made available to individuals. Copies of the insert have been translated into the mandated languages and alternate formats and are available on the electronic Library of Official Documents at: http://health.state.nyenet/revldssforms.htm. Similarly, the common application form (LDSS-2921) will undergo changes to incorporate language regarding the Medicare application requirement. Until the revised application is available, districts must include a revised version of the supplement (currently posted at http://otda.ny.gov/programs/applications/) to informational booklets LDSS-4148A, "What You Should Know About Your Rights and Responsibilities" and LDSS-4148B, "What You Should Know About Social Services Programs" (also referred to as Books 1 and 2). Pending revisions to Books 1 and 2, a supplement was created to inform individuals of changes in the Medicaid program. When making the informational booklets available to individuals, districts must include a copy of the supplement.

Effective November 1, 2017, local districts must ensure that Medicaid A/Rs age 65 or older, or turning age 65 within the next three months, apply for Medicare unless otherwise excluded. Individuals who fail to meet this requirement will have their Medicaid eligibility denied or discontinued following timely notice, as appropriate.

If an applicant fails to apply for Medicare and applied for Medicaid coverage for the three-month retroactive period, the individual will be ineligible for Medicaid prospectively and for any month in the three-month retroactive period where the condition of eligibility applies; meaning any month in which the individual was age 64 and nine months or older. The individual may qualify for assistance for the months in which the individual had not yet reached aged 64 and nine months. If an applicant provides proof of applying for Medicare following a denial or discontinuance of Medicaid but within 30 days of the effective date of the denial/discontinuance, the receipt of the documentation should be treated as a reapplication requiring a redetermination of Medicaid eligibility if all other documentation requirements were met. A new three-month retroactive period may apply based on the date the documentation is received (reapplication month). The documentation received

satisfies the requirement for the three-month retroactive period.

If a district is adding a person age 64 and nine months, or older, to an existing case, the applicant must first show proof of application for Medicare, unless otherwise excluded from this requirement.

When an individual loses eligibility for cash assistance, the individual is generally entitled to a separate Medicaid eligibility determination. When the Medicaid office performs a separate Medicaid eligibility determination, if an individual is age 65, or turning age 65 in the next three months, the individual must apply for Medicare as a condition of on-going Medicaid eligibility, unless otherwise excluded from this requirement.

A. Upstate Local Districts

1. Application

Individuals aged 65, or turning age 65 in the next three months, who are required to apply for Medicare, must document that an application for Medicare was submitted at the time of their Medicaid application. If proof is not provided with a Medicaid application, the district may need to calculate a "scratchpad" budget based on income attested to on the application, to determine if the individual has income at or below the applicable income standard or at or below 120% of the FPL. For Medicaid applicants who are required to document application for Medicare and do not submit proof of Medicare application, the district must request the required documentation using the documentation requirements form LDSS-2642. Districts should check the "Other" box and hand write "proof of Medicare application" or "Medicare determination letter from SSA" on the form. Districts should allow individuals a minimum of 15 days to submit the required documentation. Additional time beyond the initial 15 days should be allowed for individuals actively trying to meet the documentation requirement. For individuals who fail to submit proof of application for Medicare, districts must deny the individual's Medicaid eligibility using Client Notice System (CNS) Reason Code D84 (Deny Medicaid, Failed to Apply for Medicare).

Four new Anticipated Future Action (AFA) codes have been created to track the Medicare application status on WMS:

231 – Medicare application submitted
232 – Medicare application denied
234 – Income over SLMB level
235 – Deferred for Medicare Documents

AFA code 234 (Income over SLMB level) has been created to indicate that an individual has income over the applicable Medicaid level and over 120% of the FPL. Districts must enter the appropriate value in the AFA field when proof of Medicare application is received or when no proof is required, such as for people over the SLMB income level. A corresponding AFA date is also required. The date must equal the WMS Authorization Period "To" date. This field must be updated at the time of renewal.

AFA code 235 (Deferred for Medicare documents) should be used when an individual is granted additional time to provide proof of an application for Medicare (see Section 2. below for further information).

Note: Individuals who are excluded from the requirement to apply for Medicare due to immigration status do not require an AFA code.

2. Monthly Medicare Process

Beginning in November 2017, WMS will run a monthly process on the second Saturday of every month to identify active Medicaid individuals who turned age 65 in the previous month and are not otherwise excluded from the requirement to apply for Medicare. A notice generated via newly created CNS Reason Code T14 (Over 65, Request to Apply for Medicare) will be mailed to identified individuals. The notice explains how and where to apply for Medicare and instructs the individual to submit proof of application for Medicare to his or her local district by a designated due date (30 days from the transaction date).

Upon receipt of proof that an application for Medicare was submitted, districts should enter AFA code 231, 232 or 234, if applicable, with the case Authorization "To" date as the AFA date.

An automated closing process will run on the 17th of the month following the month in which the T14 notice was mailed. If the recipient is not in receipt of Medicare, and has not applied for or been denied Medicare benefits (as indicated by the AFA Code), the individual's Medicaid coverage will be discontinued. The automated closing process will generate a closing notice using a new CNS Reason Code W26 (Discontinue Medicaid, Failed to Apply for Medicare). Medicaid coverage will end at the end of the month in which the closing notice is sent. See Section 5. for information on Medicaid closings on a TA/Medicaid case.

For individuals who are granted an extension to provide proof of an application for Medicare that could extend beyond the 17th of the month following the month the T14 notice was sent, districts must enter AFA code 235 (Deferred for Medicare Documents) to prevent the individual's Medicaid coverage from being automatically discontinued. An AFA due date of up to 90 days in the future may be used with this code. If an individual does not provide the required documentation by the AFA designated due date and no additional extension has been granted, the district must discontinue the individual's Medicaid coverage using CNS Reason Code W26.

For individuals who meet the closing criteria, one of three transactions will be created in WMS:

- Closing transaction to close all individuals on a Case Type 20 when all case members are subject to closing;
- Undercare transaction to delete members on a Case Type 20 when not all case members are subject to closing; or
- Undercare transaction to change Medicaid coverage to 04 for members on Case Type 11, 12, 16 and 17.

Individuals will not be discontinued when any one of the following criteria is met:

- Case is in Pending Status;
- Case is in Clockdown Status;
- Medicare Indicator = Y; or
- AFA Code = 231, 232, 234 or 235 with an AFA date in the future.

Cases that are not discontinued due to being in pending status will appear on a new report detailed in Section 6. These cases will require review and manual closing.

3. Medicaid Renewal

The Medicaid renewal forms for community and SSI-related populations have been revised to include the following language: "If you do not have Medicare and you have End Stage Renal Disease (ESRD), or you have Amyotrophic Lateral Sclerosis (ALS), or you are 65 years of age or older, you must apply for Medicare and show proof of application unless otherwise excluded." Individuals who have been excluded from the monthly Medicare process and back-log process (see Section 4. below) must meet this requirement at renewal. Such individuals include Medicaid recipients being discharged from an OMH psychiatric facility and incarcerated individuals following release. Nursing home cases will also require review at renewal.

Referral notices that are sent to NYSOH Medicaid recipients when they are referred to the local district (CNS Reason Codes H2W, H3W and S4N) have been revised to include information about the requirement to apply for Medicare and how to apply. These cases will be reviewed by the local district when Medicaid eligibility is re-determined.

Upon receipt of proof that an application for Medicare was submitted, districts should enter AFA code 231, 232 or 234, as appropriate, with the case Authorization "To" date as the AFA date. This field must be updated at the time of the next renewal.

For individuals who fail to submit proof of application for Medicare at the time of Medicaid renewal (following notice of the requirement and a due date), districts must discontinue the individual's Medicaid coverage using CNS Reason Code W26 (Discontinue Medicaid, Failed to Apply for Medicare).

To prevent individuals who are required to apply for Medicare from being picked up by the Medicaid Administrative Renewal process, the monthly Medicare process and back-log process will identify individuals required to apply for Medicare and change the Recertification Source Code to a "2." These individuals will appear on the Recertification Notice report (WINR4133) to be renewed by the district. Once the Medicare requirement is met, the worker must remove the Recertification Source Code "2." Individuals who meet the selection criteria in subsequent years will be reinstated in the Administrative Renewal process. If there is a pending transaction when the system attempts to populate the '2', the case

will be listed in Section 2 of WINR5001 report (See Section 6. below for further information).

4. Back-log

Upstate WMS will run a one-time process on November 11, 2017 to identify active Medicaid individuals who are age 65 plus two months, or older, not enrolled in Medicare, not in a renewal cycle, and who otherwise meet the criteria to apply for Medicare. This group is referred to as the "back-log." Individuals in the back-log will receive a CNS notice using Reason Code T14 (Over 65, Request to Apply for Medicare), explaining how and where to apply for Medicare and to return proof of application or enrollment of Medicare to the local district.

Upon receipt of proof that an application for Medicare was submitted, districts should enter AFA code 231 or 232, as applicable, with the case Authorization "To" date as the AFA date. As noted in Section 2. (Monthly Medicare Process), certain individuals who are granted an extension for providing documentation of an application for Medicare may need AFA code 235 and a date up to 90 days in the future to be entered by the worker to prevent Medicaid coverage from being discontinued.

On December 17, 2017, WMS will run a one-time back-log process to identify all current Medicaid recipients who were noticed on November 11, 2017 and who are not in receipt of Medicare and have not applied for or been denied Medicare benefits (based on the AFA code). Medicaid benefits for these individuals will be systematically discontinued at the end of the month via CNS Reason Code W26.

The back-log will exclude individuals with incomes over 120% of the FPL, individuals in nursing homes, individuals in an OMH psychiatric facility and individuals who are incarcerated.

5. Temporary Assistance (TA)/Medicaid Applicants/Recipients

Individuals age 65, or turning age 65 in the next three months, who are applying for, or enrolled in Medicaid on a TA case Type, must also meet the Medicaid requirement to apply for Medicare, unless otherwise excluded. Individuals enrolled in Medicaid on a TA case will be included in the automated monthly Medicare process and back-log process described above. Based on the documentation submitted by a TA/Medicaid recipient in response to the notice received (Reason Code T14), workers must enter the appropriate AFA code (code 231, 232, 234 or 235) and AFA date. Recipients who fail to comply with the Medicaid requirement to submit proof of application for Medicare benefits, will automatically have their Medicaid coverage discontinued (changed to 04 – No Coverage) with system generated CNS Reason Code MN2 (TA/FS Unchanged, Medicaid No Coverage).

At application or recertification, TA/Medicaid A/Rs who are required to apply for Medicare, must document that an application for Medicare was submitted at the time of their TA/Medicaid application or, if applicable, at renewal. The district must request the required documentation using the documentation requirements form LDSS-2642. Districts should check the "Other" box and hand write "proof of

Medicare application" or "Medicare determination letter from SSA" on the form. Districts should allow a minimum of 15 days to submit the required documentation. Additional time beyond the initial 15 days should be allowed for individuals actively trying to meet the documentation requirement. For TA/Medicaid applicants who fail to provide proof of application for Medicare, Medicaid coverage must be denied using CNS Individual Level Reason Code MN1 (Open TA/FS, Deny Medicaid). TA/Medicaid recipients who fail to comply with the requirement to apply for Medicare and submit proof, Medicaid coverage must be discontinued using CNS Individual Level Reason Code MN2 (TA/FS Unchanged, Medicaid No Coverage). The Medicaid Coverage Code must be changed to 04 (No Coverage) following timely notice.

6. Upstate WINR Reports

The following reports will include TA/Medicaid cases.

a. WINR5001 Automated Notice for Complying with Medicare - This report will be produced at the time of the automated notification process and will consist of the following sections:

Section 1 – Cases Meeting Criteria for Medicare Noticing Process - This section will list cases/individuals identified as meeting the criteria for the automated notification process and a T14 notice will be sent through the CNS.

Section 2 – Cases with Pending Transactions Needing Recert Source Code Change – At the time of the monthly Medicare process and back-log process the system will attempt to change the Recertification Source Code to a "2" for individuals identified. If, however, the case has a pending transaction at the time of the monthly Medicare process or back-log process, the system will not change the Recertification Source Code. This section of the WINR5001 report will list cases/individuals identified as having a pending transaction at the time of the monthly Medicare process or back-log process. Districts must review the Recertification Source Code on these cases and change the code to a "2." This will prevent the cases from being selected for the Administrative Renewal process.

b. WINR5002 Automated Closing for Not Complying with Medicare - This report will be produced at the time of the automated Medicaid closing process and will consist of the following sections:

Section 1 – Cases Meeting Criteria for Medicare Closing Process - Cases/individuals identified as meeting the criteria for the automated Medicaid closing process who were discontinued or deleted will be listed.

Section 2 – Cases with Pending Transactions Needing Review - This section will list cases/individuals identified as meeting the criteria for the automated Medicaid closing process but have a pending transaction at the time of processing. These cases will require review by the worker and manual processing. For Medicaid cases, CNS Reason Code W26 can be used to manually generate a discontinuance notice if appropriate for failure to comply

with the requirement to apply for Medicare and submit proof. For TA/Medicaid cases, CNS Individual Level Reason Code MN2 must be used to manually generate a Medicaid discontinuance, if appropriate, with a Case Level Reason Code Y20 for TA and Y20 for Food Stamps, if applicable.

Section 3 – Individuals who Applied for Medicare - Individuals who applied for Medicare in the previous month as a result of the noticing process will be listed.

Section 4 – Individuals Receiving Medicare - This section will list individuals who have received Medicare as a result of the noticing in the previous monthly process. Medicaid staff should review Medicaid cases for MSP eligibility and accretion to the Buy-in. TA staff should accrete TA/Medicaid recipients to the buy-in (see Section V. of this directive for further information about Buy-in).

All sections in each report will be sorted by: District; Local Office; Unit; Worker; and Case Name (Alphabetically). Each record in each section will contain the following information: Case Number; Case Name; Case Type and CIN. At the end of each section, additional records will contain the total number of cases for each Worker ID on the report. At the end of the report, the final records will contain the total number of cases on the report for each section. The reports will be available through BICS for upstate districts and will be delivered to State staff, OMH (District 97) and the Office for People with Developmental Disabilities (District 98) through PHRED.

B. New York City

1. Medicare Application Indicator (MAI)

A new worker entered data field, Medicare Application Indicator (MAI), has been developed to track individuals' status during the Medicare application process. The new field will also be utilized in the automated Medicaid closing process (back-log, see Section 6.)

At the time of application processing, workers must enter a value in the MAI field to identify whether the Medicare requirement has been met based on the documentation provided by the individual. This is a required field and must be updated at eligibility, renewal, undercare, or whenever new Medicare documentation is received. The following describes the various MAI values. The MAI values are allowed with the following Medicare Indicator Codes (MCR) from RFI or eMedNY:

MAI	**RFI MCR or eMedNY MCR**
A (Applied for Medicare)	N or Blank
D Deferral MCR	N or Blank
P Verified MCR	Y Manual entry
V (Verified has Medicare)	Y System Generate
Blank MCR	N or Blank
S (SLMB Ineligible)	N or Blank
N (Not Medicare Eligible)	N or Blank

2. Application

Individuals age 65, or turning age 65 in the next three months, who are not excluded from the requirement to apply for Medicare, are required to show proof of Medicare at the time of Medicaid application, including TA/Medicaid applications. For applicants who are required to show proof of application for Medicare as a condition of eligibility for Medicaid, who do not submit proof with the application, the district must follow the instructions listed under Section 4. "Deferrals."

3. Medicaid Renewal

A revised High Priority DAB (Disabled, Aged and Blind) renewal insert was available in WMS production as of February 2017. It includes information about the Medicaid requirement to enroll into Medicare and the documentation that should be returned with the renewal application. If documentation is not provided with a renewal and an individual is otherwise required to apply for Medicare as a condition of eligibility for Medicaid, the district must follow the instructions listed under Section 4. "Deferrals." Nursing home residents over age 65 who are not enrolled in Medicare will be removed from the automated chronic care renewal process and will receive the DOH-4411, "Recertification for Medical Assistance (Chronic Care)" renewal with an insert explaining the requirement to apply for Medicare (OHIP-0112).

Individuals who must meet the Medicare requirement at the time of renewal, and who have been excluded from the back-log process are: parent/caretaker relatives; individuals discharged from an OMH psychiatric facility; and incarcerated individuals upon release. Medicaid cases referred from NYSOH will also require review when eligibility is re-determined.

4. Deferrals

When partial documentation is returned with the application or renewal form, workers are instructed to process the case as follows to determine if the case should be deferred for documentation of proof that an individual applied for Medicare:

a. If Medicare information is not submitted with an application or renewal and all other renewal documents have been returned, Medicaid workers should complete a pending MSP budget using the Buy-In Indicator "A." The pending budget must be stored. If the budget message returned is either "QI" (eligible) or "MSP ineligible," then the worker should update the MAI field with the value "S" (SLMB ineligible) and continue to process the application/renewal. No documentation concerning an application for Medicare is required. If the pending budget message returned is QMB or SLMB eligible then the case should be deferred to request proof of Medicare application using Deferral Code K08 (Verification of Application for Medicare Benefits).

b. If income and Medicare documentation are not submitted with an application or renewal, workers should use the attested income from the application or renewal form and complete a pending MSP budget using the Buy-In indicator "A." The pending budget must be stored. If the budget message returned is either "QI" (eligible) or "MSP ineligible", then the worker should update the MAI field with the value "S" (SLMB ineligible) and defer for income only. If the pending budget message returned is QMB or SLMB eligible then the case should be deferred for income and proof of Medicare application (Deferral Code K08 – Verification of Application for Medicare Benefits).

c. If an individual has a State and Federal Charge Code of 67, the worker should not defer for Medicare as the individual is not a lawful permanent resident and is not Medicare eligible. An individual with a State and Federal Charge Code of 60 or 68 will have a Date Enter Country (DEC) of less than five years and should not be deferred as the individual is not Medicare eligible.

d. Individuals who are required to provide proof of application for Medicare benefits who fail to submit proof by the designated due date will be denied or discontinued Medicaid using one of the following new Reason Codes:

- H22 – Denial, Failed to Comply with Medicare Requirement
- H51 – Discontinuance, Failed to Respond to Over 65 Medicare Mailer

5. Administrative Renewals

Medicaid recipients over age 65 with a Medicare Indicator Code (MCR) not equal to Y or a Medicare Application Indicator (MAI) not equal to V will be removed from the auto-renewal process and will receive a DAB renewal. Once the Medicare requirement is met, the individual will be evaluated for inclusion in future auto-renewals.

6. Back-log

The Department will identify active Medicaid and TA/Medicaid individuals with a birth date of August 1952 or earlier with an MCR Indicator or internal eMedNY Medicare Indicator not equal to Y and not in a renewal cycle. Cases with Surplus Case Opening Codes H72, H91, or H76, records with Origin ID 588 (nursing home), Coverage Code equal to 07 and State Federal Charge Code equal to 60, 67, or 68 will be excluded from the selection.

This group is referred to as the "back-log". A system generated CNS notice, Reason Code MCB (Over 65, Request to Apply for Medicare), will be generated requesting the individuals to apply for Medicare. The notice explains how and where to apply for Medicare and to return proof of application or enrollment of Medicare to the Human Resources Administration.

The NYC back-log cases will be divided into three separate mailings due to the large volume of cases to be noticed and the manual work involved in coding responses received. The first mailing will occur on or about October 30, 2017. It

is anticipated that the second and third mailings will be scheduled at three to four month intervals. TA Case Types 11, 12, 16 and 17 will run concurrent with the Medicaid mailings.

A CNS clocking closing transaction will be triggered on the 45th day after the back-log notice is mailed. Prior to processing the closing transaction, the record will be cross checked against the MCR Indicator, the internal eMedNY Medicare Indicator Code and the new MAI field for updates.

If the MCR or eMedNY Medicare Indicator is equal to Y, or the MAI field is populated with a value of A, D, P, V, S, or N, then the closing transaction will be canceled. Manual cancellation transactions are also allowed. Fair Hearing updates are allowed on the pending transaction. Unsuccessfully processed records in pend (02) status will be added to the daily disposition reports WINR0125 and WINR0126.

Two new system generated CNS codes will be used to address recipients in the back-log who fail to comply with the Medicare requirement; 693 - Discontinuance, Failed to Respond to Over 65 Medicare Mailer for Case Type 20 and 698 - Discontinue, Failed to Respond to Over 65 Mailer for TA/Medicaid Case Types 11, 12, 16 and 17.

EDITS and POS have been updated to support the policy in this directive.

V. BUY-IN

At the time of application, renewal, or in response to back-log noticing and monthly Medicare processing, districts are required to evaluate Medicare beneficiaries for the Medicare Savings Program (MSP) and if eligible, add the individual's Buy-in span(s) to eMedNY. TA/Medicaid recipients who are entitled to payment of Medicare Part B premiums and should be accreted to the Buy-in on eMedNY with a Buy-in Code of "P."

Note: Individuals who have submitted a Medicaid application, including the LDSS-2921 common application, are not required to submit a separate MSP application.

The Medicare Savings Program must also be considered for Medicaid enrolled individuals in a MAGI eligibility group who have Medicare, such as parents and caretaker relatives. In this situation, the district must perform the MAGI-like budget and then perform an SSI-related budget for MSP eligibility. If the individual is eligible under the MAGI-like budget and at or below 120% of the FPL (SLMB level), the MAGI-like budget should be stored and the case coded in WMS accordingly. A copy of the MSP budget should be stored in the case record and the individual accreted to the Buy-in. If the individual is eligible under the MAGI-like budget but income is over the SLMB level, the district must make a MIPP payment to reimburse the individual for the Part B premium.

Note: Individuals enrolled in Medicare Part A, but not Part B should be evaluated for the Medicare Part B Buy-In. If there is no deduction for the Part B premium in the MSP budget, and the person is below 120% FPL, the individual should be accreted to the Buy-in for Part B. For further information regarding eligibility determinations for Medicare

beneficiaries who have Medicare Part A or Medicare Part B, districts should refer to the Office of Health Insurance Programs, Dear Commissioner Letter, dated January 31, 2017, and subsequent letter, dated July 31, 2017, which contained additional guidance.

VI. SYSTEMS IMPLICATIONS

A. eMedNY

In December 2017, the monthly "Medicare Warning Letters" (Attachment III) generated by eMedNY for Medicaid recipients who are age 64 and nine months, will be revised to include information on how and where to apply for Medicare and the requirement to submit proof of application for Medicare benefits to the local district office. Letters to individuals with ESRD will also be generated by eMedNY.

B. Upstate WMS

Districts should refer to the September 28, 2017, WMS/CNS Coordinator Letter, for information concerning Error Code changes that were made to support the policy in this directive.

C. NYC WMS

New York City should refer to WLM 2017-00147-07 and the Worker Guide to Codes for a description of the new Reason Codes and Edits that are being made to support the policy in this directive.

VII. EFFECTIVE DATE

The provisions in this Administrative Directive are effective November 1, 2017.

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs