

# MEDICAID ALERT

## Medicare Enrollment

December 13, 2017

The purpose of this Alert is to provide organizations assisting Medicaid consumers with information regarding the requirement for certain Medicaid applicants/recipients (A/Rs) to apply for Medicare as a condition of Medicaid eligibility.

Medicaid applicants/recipients who appear to be eligible for Medicare benefits are required to apply for Medicare as a condition of Medicaid eligibility. 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. This includes recipients receiving Medicaid on a Temporary Assistance case.

### **I. Medicare Eligibility**

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 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 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 US 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 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 and individuals eligible for the Medicare

Savings Program do not have to wait for the GEP to enroll in Medicare. They are eligible to enroll in Medicare at anytime. Fully Medicaid recipients and individuals eligible for the Medicare Savings Program may be enrolled into the Medicare Savings Program at any time during the year if the individual has established Medicare entitlement with the SSA.

## **I. Medicaid Program Implications**

### **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) and who are age 64 and 9 months or older must apply for Medicare as a condition of eligibility for Medicaid. This requirement applies to Medicaid only applicant/recipients as well as cash assistance/Medicaid applicant/recipients.

### **B. Individuals Excluded from the Medicare Requirement**

Individuals who are presumptively eligible for Medicaid, 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. Most immigrants and non-citizens are excluded from this requirement. Only lawful permanent residents who have lived continuously in the U.S. 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 a proof of application. The award or denial letter, a copy of the Medicare card, or the printed on-line confirmation, are all acceptable forms of documentation.

### **Consumers Applying for Medicaid**

Consumers aged 64 and 9 months or older who are applying for Medicaid will be required to apply for Medicare unless otherwise excluded. The OHIP-0112 has been added to our application kits to explain this requirement to applicants until the DOH 4220 can be revised. 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 (i.e. the consumer was aged 64 and 9 months or older). The individual can qualify for assistance for the months in which the individual had not yet reached age 64 and 9 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 will be treated as a reapplication. Medicaid eligibility will be redetermined 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.

The Medicare requirement will also be applied when an individual aged 64 and 9 months or older is requested to be added to a case, or when an individual applies for a separate determination after losing cash assistance benefits.

#### **E. Consumers Renewing their Medicaid**

HRA's renewals for disabled, aged, and blind consumers, including those turning 65 include a notice regarding the Medicare requirement. If renewals are received for consumers aged 64 and 9 months or greater who appear to meet the income standard for the Medicare requirement but are not in receipt of Medicare, the client will receive a deferral for proof of Medicare application. If consumers fail to submit the required proof of application, their coverage will be discontinued. Consumers can request more time to provide the proof of Medicare application if needed by calling the Medicaid Helpline (888 692-6116).

#### **F. Consumers already in Receipt of Medicaid**

While the requirement to enroll in Medicare is not new, recent audits have found that it has not been consistently enforced across the state. Therefore, the New York State Department of Health (SDOH) has developed a project to identify consumers turning 65 or aged 65 and above who appear to meet the requirements of Medicare but who have not yet enrolled. This project will target consumers who have not enrolled in Medicare at all (not those enrolled only in Part A or only in Part B). These consumers (if not currently in the renewal cycle (see consumers renewing above)) will receive a notice requiring the individuals to submit proof of application for Medicare. Consumers eligible for Medicaid with a surplus, consumers in a nursing home, and consumers in the 5 year ban will be excluded from this selection. Surplus consumers with incomes at or below 120% of FPL and Nursing Home consumers will be subject to the requirement at renewal unless otherwise excluded. If an individual does not provide the required proof by the designated due date (approximately 30 days

from the notice date), the consumer will be sent a Notice of Intent to close their Medicaid coverage and the case will close 14 days from the Notice date. Prior to selection for closing,

however, system records will be checked to determine if the Welfare Management System now shows Medicare coverage for the individual. If the consumer has provided proof of application or denial or if the Welfare Management System now shows Medicare enrollment, the client's coverage will not be terminated.

In New York City, this notice process for current Medicaid only recipients will be divided into three separate mailings. The first mailing is expected to go out in early- mid December with the second and third mailings expected to occur in three to four month intervals.

Medicaid only consumers in this group who request more time to comply will be issued a new deferral and will receive a notice with a new due date. This process will allow us to properly track these consumers.

### **G. Consumers Needing More Time**

If an A/R or the A/Rs legal representative requires additional time to meet the documentation requirement, additional time will be allowed. For Medicaid only clients, client representatives should submit MAP 3062(c) to the Undercare Processing Division to request more time for their clients. Alternatively, consumers or their representatives can call the HRA Medicaid Helpline (888-692-6116) to request additional time.

For additional information please see 17 OHIP/ADM-01 Medicare Enrollment at Age 65.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

**REQUEST FOR A TIME EXTENSION:  
MEDICARE APPLICATION**



Date: \_\_\_\_\_

Case Name: \_\_\_\_\_

Case Number: \_\_\_\_\_

CIN: \_\_\_\_\_

I am unable to provide the documentation that HRA requested at this time. I am requesting additional time past the deferral due date that HRA provided. I understand that this extra time will delay the final processing of my case which could result in an eligibility determination taking longer than the normal case processing timeframe of 30 days for a case containing a child, 45 days for a case containing adults only, or 90 cases for a case based on a disability.

**INITIAL EXTENSION REQUEST** (place a checkmark in the appropriate box or boxes)

My due date to provide documents is \_\_\_\_\_.

I am requesting the following:

Up to \_\_\_\_\_ additional calendar days to give you my documents

Reason for Extension: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOLLOW-UP EXTENSION REQUEST** (place a check in the box below if this is **not** your first extension request)

I am requesting up to \_\_\_\_\_ additional calendar days to give you my documents

Reason for Extension: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please tell us what you have done to get the documents. Include the name and contact information of the third party contacted (e.g. Bank, Life Insurance Company, Pension Company, IRS, SSA, etc.) the dates contacted and the response received. Attach any relevant correspondence.

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I understand that if I do not provide the documents requested by the date it is due, or send HRA a request for an additional extension explaining why I need more time, HRA will make an eligibility determination based upon the documents and information on file and:

My application may be:

- Denied for Medicaid. HRA will not authorize Nursing Home coverage or any other type of Medicaid coverage
- Determined eligible for Medicaid Community Coverage **with** Community Based Long Term Care; **only**
- Determined eligible for Medicaid Community Coverage **without** Long-Term Care, **only**

Name of Consumer/Representative (Print)	Name of Consumer/Representative (Sign)	Date

**Do you have a medical or mental health condition or disability?** Does this condition make it *hard for you to understand this notice or to do what this notice is asking?* Does *this condition* make it hard for you to get other services at HRA? **We can help you.** Call us at 212-331-4640. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law