ADMINISTRATIVE DIRECTIVE

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
40 North Pearl Street
Albany, New York 12243
Cesar A. Perales, Commissioner

TRANSMITTAL NO: 89 ADM-7

DATE: February 27, 1989

DIVISION:

TO: Medical Assistance

Commissioners of Social Services

SUBJECT: Implementation of the Medicare Catastrophic Coverage Act of 1988 (MCCA) Relating to the Medicaid Payment of Medicare Premiums, Deductibles and Coinsurance

SUGGESTED DISTRIBUTION:
Medical Assistance Staff
Third Party Staff
Accounting Staff
SDX Coordinators
Staff Development Coordinators
Public Assistance Staff

CONTACT PERSON: Any MA Program questions concerning this release should be directed to the Division of Medical Assistance by calling your County Representative at 1-800-342-3715, ext, 3-7581, or the New York City Office at (212) 587-4853.

Questions regarding provider enrollment and the EMEVS card should be referred to your MMIS county representative at ext. 4-9033.

I. PURPOSE

The purpose of this Administrative Directive is to advise local social services districts of the actions necessitated by the enactment of the Medicare Catastrophic Coverage Act of 1988 (MCCA) as amended by the Family Support Act of 1988 (FSA) and the Technical and Miscellaneous Revenue Act of 1988, concerning payments for deductibles, coinsurance and Medicare premiums under Medicaid.

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Department Regs.	Social Services Law and Other Legal References	Manual References	Miscellaneous Reference
87 ADM-40 86 ADM-47 86 ADM-46 83 ADM-65 80 ADM-56		360-2.1 360-2.2(f) 360-4 360-6.2 360-7.7 360-7.8	367-a P.L.100-360 P.L.100-485 P.L.100-647		1988 Laws MCCA FSA Tech. & Misc. Rev. Act

II. BACKGROUND

Medicare eligible ADC and SSI recipients have their Medicare premiums paid through the Buy-In system. Prior to the passage of the MCCA of 1988 these payments were limited to SSI recipients; ADC cash recipients; and certain other groups of persons, i.e., persons qualifying under sections 503, and 249E of Public Laws 94-566 and 92-603 respectively; and, section 1619B of the Social Security Act (Public Law 99-509) (Substantial Gainful Activity). Under the new legislation these groups have been expanded to include certain Medicare beneficiaries with incomes at or below the federal poverty level and resources at or below twice the SSI standard. This new group is referred to as Qualified Medicare Beneficiaries (QMBs).

All Medicaid payments for Medicare coinsurance and deductibles are in accordance with the appropriate Medicaid fee or rate schedules.

III. PROGRAM IMPLICATIONS

As a result of this new provision, increased numbers of persons will be eligible for Buy-In and local districts shall be responsible for the local share of the Medicare Buy-In program costs. Many of the affected persons are currently active medically needy elderly and disabled recipients whose Medicare premiums are being deducted from their gross Retirement, Survivors, Disability Insurance (RSDI) benefits. Many of these individuals may now be permitted to retain a higher amount of their income.

The MCCA of 1988 requires that Medicaid be available to pay deductibles and coinsurance for both Medicaid and Medicare services for this new group of eligibles. This means that providers who are not currently actively enrolled in the Medicaid program must now apply for enrollment in order to receive deductible and coinsurance payments on behalf of QMBs. Instructions for applying for enrollment are contained in the attached Dear Health Care Provider Letter (Attachment 4).

IV. REQUIRED ACTION

Local social services districts shall determine eligibility for the Medicare Buy-In Program for all potentially eligible persons as follows:

A. Persons Affected/Qualified Medicare Beneficaries (QMBs)

Qualified Medicare Beneficiaries (QMBs) are defined as:

Medicare beneficiaries whose income is at or below the federal poverty level, whose resources are at or below twice the SSI resource standard, and who meet certain other Medicaid criteria (Section IV. C). This includes most active Buy-In (e.g., SSI, ADC, etc.) recipients.

NOTE: Persons between 21-65 in State Psychiatric Centers, although not eligible for on-going Medical Assistance, are entitled to benefits under the Medicare Buy-In Program. These

cases will be handled by the Office of Mental Health in conjunction with the New York State Department of Social Services, Cooperative Institution Section.

B. Benefits/Covered Services

1. All QMBs are eligible to have Medicaid pay the appropriate Medicare premium(s) on their behalf (primarily Part B, although Part A is paid in accordance with existing Buy-In procedures). That is, the individual must already be in receipt of and paying Medicare Part A premiums in order for Part A premiums to be paid under this program. The individual must be in receipt of or entitled to Medicare Part A and in receipt of Medicare Part B in order to have the Part B premium paid under this Buy-In Program.

2. All QMBs are eligible to have Medicaid pay deductible and coinsurance for all services offered under Medicare. This includes Medicare Services not covered under Medicaid (i.e., chiropractor).

C. Procedures

1. Non-Financial

a. Application/Recertification Procedures

1. Currently, active Buy-In recipients and those who attain future eligibility because of the receipt of SSI, ADC or who are members of any of the special groups (249e, etc.), cannot be required to file a separate application for Buy-In coverage. For active MA Only recipients eligibility for benefits under the Medicare Buy-In program shall be determined using the most current DSS-2921 or DSS-3174 (Medical Assistance Application/ Recertification forms).

2. All other persons requesting Medical Assistance to pay for benefits/covered services through Buy-In must file an application and complete all sections of the DSS-2921. For persons found eligible the DSS-3174 should be used to recertify eligibility under the Medicare Buy-In Program.

3. Except as otherwise specified in this ADM, all of the policies and procedures contained in section 360-2 of Department regulations relating to application(s)/recertification(s) shall apply to all applicants/recipients (A/R's) of the Medicare Buy-In Program. Local districts are reminded that in cases where the A/R or representative is not able to appear in the agency for the personal interview, arrangements shall be made for a home visit. It is suggested that initial authorization periods be staggered to avoid an entire caseload coming due at the same

recertification period. Buy-In cases may not be recertified more than once every six months, but must be recertified at least once every twelve months.

4. Applicants who appear to be eligible for Medicare should be referred to their local or regional Social Security Administration office for a determination of Medicare eligibility. This applies primarily to persons who have been receiving RSDI benefits for at least twenty-four months, who have attained the age of sixty-five, or who have end-stage renal disease. Persons in receipt of Part B only should also be referred to the Social Security Administration for a determination of their Part A entitlement. Likewise, persons who appear to be eligible for Medical Assistance shall have their eligibility determined under the Medical Assistance Program.

   All recipients not in receipt of Medicare shall be reevaluated at the time of any case change (e.g. decrease in income, person attains age 65) and/or at recertification for potential eligibility for Medicare. Districts are reminded however, that the general enrollment periods for medical insurance (Part B) is limited to the first three months of each calendar year (January through March).

5. Local districts may also request from this Department a waiver of the personal interview for **recertification,** in accordance with section 360-2.2(f) of Department regulations and 86 ADM-47. Such requests must be submitted in writing to:

   Marilyn Solomon, Field Team Head
   WMS/MA Systems and Field Operations
   NYSDSS Division of Medical Assistance
   40 North Pearl Street
   Albany, NY 12243

   Local districts may also request approval to establish a screening process for applications for the **Buy-In** Program. Districts may consider using a cover letter (Attachment 3) to accompany the application packet that would be mailed pursuant to the request or inquiry of an individual.

Such waivers shall not be applicable for periods beyond September 30, 1989.

Local districts must receive written authorization from the Department in accordance with Sections 12.1, 12.2 and 12.3 of the Local District Manager's Guide prior to implementing a screening process. The following conditions must be addressed in any proposal submitted:

i. The face-to-face interview is required unless the case is being denied up-front. The only reason a case may be denied up-front is due to excess resources. Because of potential errors, it is suggested that local districts proceed with a face-to-face interview in cases where the excess resource amount is less than $50.

ii. An application (DSS-2921) must always be mailed in response to an inquiry.

iii. Any cover letter that is sent to the individual must include the information that the individual is entitled to a full interview, even if the application qualifies for a denial based upon the statements contained on the application. (See Attachment 3 for Suggested Letter to Medicare Beneficiary.)

iv. The individual must be given his/her full appeal rights as contained on the mandated notices. (See Attachments 1 and 2.)

Note: Local districts may apply for options that will allow a case to be denied up-front, but in no instance can a case be accepted without a face-to-face interview.

b. Documentation

All A/Rs of the Buy-In Program must document the following items of eligibility:

-Identity
-Household Composition
-Residence
-Citizenship/Alien Status
-Social Security Number
-Transfer of Property
-Income/Resources
-Entitlement to or receipt of Medicare Part A
-Receipt of Medicare Part B

c. Authorization Procedures

Eligibility may be authorized three months retroactive to the date of **receipt** of the written application, but in no

event can an authorization be made for any period prior to January 1, 1989. When determined eligible, MA coverage dates shall begin on the first day of the month but may terminate on any day of the month in accordance with section 360-6.2 of Department regulations.

2. Financial

a. Income/Resource Standards

All A/Rs for the Buy-In shall have their eligibility determined according to SSI budgeting methodologies except that the following income and resource standards shall be applied:

Income Standards

Number in Applying Household	One	Two
Net Annual Income (including Part B premium amount)	$5770	$7740
Net Monthly Income	$ 481	$ 645

Resource Standards

Number in Applying Household	One	Two
	$4000	$6000

As with other SSI related persons, A/Rs of the Buy-In Program may set aside up to $1500 as a burial fund for themselves and/or their spouses. A couple is allowed to set aside $3000.

b. Budgeting

1. Treatment of Income

Any Medicare Buy-In retroactive lump sum payment received by a QMB is exempt for purposes of both Buy-In and Medicaid eligibility for themselves and all members of the household for whom the individual is legally responsible. It is important to note, however, that such payments must be included (in the month of receipt) when calculating the Net Available Monthly Income (NAMI) for persons in chronic care status.

When the A/R resides with other legally responsible and/or dependent relatives the process of allocation and deeming shall be used as appropriate. All of the

SSI-related disregards (i.e., $20, $65 + 1/2) as contained in Department regulation 360-4 and 86 ADM-46 are applicable to these new A/Rs, except as otherwise specified in this ADM.

Persons who are institutionalized should be budgeted as if they resided in the community. Thus, they are entitled to the SSI related disregards, (i.e., $20, $65 + 1/2, court ordered support), only for purposes of determining their eligibility for the Medicare Buy-In program. (See Example IV in Attachment 6.)

In determining eligibility for the Medicare Buy-In Program the cost of the Medicare Part B premium shall not be deducted from the client's gross income. Such amounts shall, however, be deducted in the Medicaid eligibility determination for so long as the expense is paid by the client. Once the district is notified by this Department that these payments are being paid through Buy-In, the individual's MA Only budget must be adjusted to reflect the elimination of the third party payment as a deduction which results in an increase in net income. Other non-Medicare third party health insurance costs continue to be an allowable deduction under both programs.

NOTE: It is also important to note that except for costs of impairment-related work expenses of the certified disabled (83 ADM-65), costs incurred for medical care are not considered in determining net income under the Medicare Buy-In program. Thus, applicants for eligibility under these new provisions may **not** spend down income (or resources) to meet the eligibility criteria.

In some instances the loss of the Medicare premium as an income deduction will result in a person losing full Medicaid coverage. When this occurs the person **must** be given a clear explanation of the budgetary implications when the Medicare premium is no longer a deduction for Medicaid eligibility. These persons should be given the option of continuing to pay for the Medicare premium, especially if the individual regularly utilizes medical care and services which are covered by Medicaid. Consideration should also be given to the impact on any remaining family members and their eligibility for Medicaid in the event that the Medicare premium is not deducted from the individual's income. (See Example V in Attachment 6.) Likewise, persons in chronic care must also be given the option of continuing to pay for the Medicare premium, since a change to Buy-In will have no effect on the amount of income they are permitted to retain. Please note however that in spousal situations eligibility for Buy-In must be determined since such a change could affect the amount of income available to the community based spouse.

c. Transfer of Property

Department requirements regarding transfer of property shall be applicable to A/Rs of the Medicare Buy-In Program.

2. Household Size

Eligibility for the Medicare Buy-In Program is established by comparing the total net income to the appropriate income standard for one or two persons as specified in Section IV.C.2.a. Household size budgeting methodologies required pursuant to Rickey v. Perales (86 ADM-46) shall not be applied in determining a person's eligibility under the Medicare Buy-In Program. For example, cash assistance recipients (SSI, ADC, or HR) and their income/resources are invisible for purposes of determining an A/R's eligibility for Medicare Buy-In.

3. Identification/Notification of Affected Persons

a. New DSS Cases

There will be no formal mailing by the Social Security Administration to potential eligibles. Advocate agencies are planning some outreach work and will be assisted by the state whenever possible.

b. Undercare Caseload

For purposes of this program, an undercare case is defined as any MA case which was active on January 1, 1989 or after. All active MA recipients who are Medicare beneficiaries have a right to a computation of eligibility for the Medicare Buy-In Program retroactive to January 1, 1989 without having to request it. This means that all potentially affected cases including those closed between January 1, 1989 and the date of this release are to be rebudgeted retroactive to January 1, 1989.

Local districts shall identify and budget active individuals at the time of recertification or next client contact (including case closing), whichever occurs first.

Active cases where the local district is currently paying all or part of the Medicare premium pursuant to the provisions of 87 ADM-40 must be reviewed for eligibility under this program. Any of these individuals found to be fully eligible should be added to the Buy-In prospectively.

Eligibility for Medicare Buy-In is likely to exist in instances where the local district has been reimbursing the full Medicare premium to an individual.

To assist local districts in identifying affected persons, a report will be produced from the MBL flat file and made available to districts upon request. This report will list cases/budgets with individuals in receipt of Social Security or Railroad Retirement income whether or not a Medicare Part B Premium exemption is associated with such income. The report will also provide the appropriate net income and the appropriate poverty level based on the living arrangement.

At local district option affected persons can also be identified by using a mass mailout to the entire caseload or through a manual review or other procedure (i.e., own computer system) which may necessitate identification of a broader group of active cases.

c. Noticing

A/Rs of the Medicare Buy-In Program are entitled to both adequate and timely notice concerning their eligibility. Local districts shall use the notices contained in this ADM as Attachment 1 DSS 4039 [Notice of Action on Application/Benefit for the Medicare Buy-In Program] and Attachment 2 DSS 4040 [Notice of Decision on Eligibility for the Medicare Buy-In Program (Active MA Only Recipients)]. These notices are mandated and must be locally reproduced until such time as they become available as state issued forms. Their content shall not be modified. When a case is accepted and Attachment 1 or 2 is sent, Attachment 4 shall also be included.

Persons accepted, denied or discontinued for Medical Assistance shall be advised of any actions concerning his/her Medical Assistance Only eligibility by a separate MA Only Notice, as contained in 84 ADM-41.

In addition, it is suggested that local districts amend their current client letter regarding recertification procedures to include a statement that specifies that the purpose of the personal interview and/or completion of the recertification form is also to review their continued eligibility for Medicare Buy-In.

It should be noted that Attachment 2 is a one-time only form and its use is to be discontinued when all potentially eligible active MA Only recipients have been notified about their eligibility for the Medicare Buy-In Program.

4. Buy-In Procedures (Upstate)

QMB individuals, as a new Buy-In group, require special identification and entry for input to the Buy-In. The following are interim procedures which will be in place until a Buy-In Subsystem is implemented for WMS, and systems support for the additional elements in the Buy-In file are implemented.

a. LDSS Input

1. Accretion of a QMB individual on Buy-In:

i. The form DSS-3281 Third Party Resources or local equivalent should be completed as usual, entering the Medicare Data for the individual. It is suggested that the following information be made available for the Buy-In worker:

- Client Identification Number (CIN)

- Whether the individual is to be accreted or deleted to the Buy-In.

- QMB Effective Date

- Sex

- Date of Birth

ii. Use standard Buy-In input form, DSS-1044 "Monthly Report of Additions to Buy-In List for Title XVIII".

iii. Enter data the same as for a regular Buy-In individual, except the letter "P" should be entered in the cents field of the SSA Benefit Amount in column 7. Standard accretion codes such as "61" should be used in conjunction with the "P" code. (Note: The dollar field in column 7 should be left blank.)

iv. If an entry already exists in the cents field of the SSA Benefit amount in column 7 it can be replaced with a "P" using another accretion transaction.

2. Deletion of a QMB individual on Buy-In:

i. Use standard Buy-In deletion form, DSS-732 "Monthly Report of Deletions to Buy-In List for Title XVIII".

ii. Enter data the same as for a regular Buy-In individual, using the standard deletion codes.

3. To facilitate identification of Buy-In individuals and provide for the transition to a Buy-In subsystem, client specific identifiers should be used instead of Case Number in column 10 of the DSS-1044 and DSS-732.

Upstate WMS districts, with numbers 01 through 57, should use the WMS CIN number in place of the Case Number in column 10 of the DSS-1044 and DSS-732. Change of existing Case Numbers will be accomplished using the Buy-In Code 99 function, however this is not currently system supported. Local districts will be notified when this is available.

The Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities should enter their three digit Facility number in the Category Field in Column 7 of the DSS-1044 and DSS-732, and their seven digit Consecutive Number in the Case Number field in Column 10.

Local Districts who have copies of HCFA publication #24 "State Buy-In Manual on Supplementary Medical Insurance Enrollment" should note the following transaction codes in Chapter IV, which are <u>not</u> currently system supported by NYSDSS:

Accretion Code "64"
Deletion Code "81"
Simultaneous Accretion/Deletion "75" "76"
Change Code "99"
Transaction "25xx" Subcodes "A" through "S"
SSI Status Code "C" through "Z"

Local Districts will be notified when these codes are supported by the NYSDSS Buy-In system.

b. <u>HCFA Output</u>

A new transaction code, 21 F, has been developed to reject an attempted accretion for a QMB if the claim number in the accretion matches the HCFA file, but the file does not reflect Medicare entitlement.

When this code is received on the Buy-In Lists received by LDSS, the accretion should either be discontinued or, when individuals appear eligible, they should be referred to the local Social Security Office.

The definition of the rejection Transaction Code 4999 has been expanded to read as follows:

"Transaction Code 4999 -- Informs the State or local social service district that a request to correct the Sex Code, Buy-In Eligibility Code, or Welfare Identification Number (Client

Identification Number) on a master record was rejected because the claim number or State Agency Code in the Code 99 did not match a master record on the Third Party Master. This code is also used to inform the State or local social services district that a code 99 with a Buy-In Eligibility Code of 'P' was rejected because it matched a master record for a beneficiary who does not have Part A entitlement."

5. Buy-In Procedures (New York City)

The New York City WMS Medicare screen NCEM35 and the undercare subsystem will be modified to allow for entry of Buy-In data. The systems availability date for these changes will be communicated in a separate transmittal.

V. SYSTEMS IMPLICATIONS

A. WMS/UPSTATE

1. MBL

System changes to support the determination of Buy-In eligibility became available on Production on February 27, 1989.

In summary, the entry of a new BUY-IN Indicator Code for BT's 04-10 will calculate and display Buy-In eligibility information for the budget.

For more information please refer to MBL Transmittals 8[illegible]1, dated February 10, 1989.

2. WMS Instructions

For QMB individuals who are eligible for payment through MMIS of only Medicare coinsurances and deductibles, the following rules apply:

Screen 1
- The Case Type must be 20 - MA Only.

Screen 4

- Entries should be made in the Medicare fields using normal local procedures. (See section IV.C.2.b.4.a.1.i., page 10 of this directive regarding procedures for completion of the DSS-3281.)

Screen 5
- Recipient MA Coverage Code must be 09-Medicare Coinsurance and Deductible Only.
- The Recipient MA Coverage From Date must not be prior to January 1, 1989.

For QMB persons who are also eligible for MA, normal coding procedures apply.

B. WMS/New York City

1. MBL

The MBL system will be modified to perform a separate calculation for Buy-In eligibility. The systems availability date for the MBL changes will be communicated in a separate MBL transmittal.

2. WMS Instructions

QMB individuals who are eligible for payment through MMIS of only Medicare deductibles and coinsurances must be case type 20. The initial eligibility transaction for a QMB must include a coverage code 09, a Medicare A and B record, and a Buy-In accretion record. The Medicare record for QMB's cannot include a To Date.

For QMB individuals who are also eligible for MA, normal coding procedures apply.

C. EMEVS

MA ID cards should be issued using the normal procedures and established card codes. The restriction of services for persons eligible only for benefits under the Medicare Buy-In Program will be accomplished through the provider message associated with the new coverage code. Active MA recipients with full MA coverage who are also found to be eligible under the Medicare Buy-In Program shall continue to be coded 01. Reference is made to Attachment 5 for the letter to the Health Care Provider regarding eligibility verification through EMEVS.

D. MMIS (Fiscal Agent)

The new MA eligible population will be identified in MMIS with a new coverage code (DE 1380) value of "D" - Medicare Coinsurance and Deductible Only. In addition to paying the Medicare premium, through an existing off-line process, Medicaid will pay the deductible and/or coinsurance for the Medicare covered services to providers who enroll in MMIS.

VI. OTHER

Attachment 1 - DSS 4039 - "Notice of Action on Application/Benefit for the Medicare Buy-In Program"

Attachment 2 - DSS 4040 - "Notice of Decision on Eligibility for the Medicare Buy-In Program (Active MA Only Recipients)"

Attachment 3 - "Suggested Letter to Medicare Beneficiary"

Attachment 4 - "Dear Health Care Provider Letter" - Instructions regarding MMIS enrollment

Attachment 5 - "Dear Health Care Professional Letter" - Information regarding EMEVS

Attachment 6 - Examples (I-V)

VII. EFFECTIVE DATE

This ADM is effective March 1, 1989 retroactive to January 1, 1989.

Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance