CATEGORICAL FACTORS

MEDICARE SAVINGS PROGRAM

Policy: Certain A/Rs who receive Medicare may be eligible for Medicaid to pay the Medicare premium, coinsurance and deductible amounts.

References:

SSL Sect. 366
366-ee
367-a(3)a

ADMs 10 OHIP/ADM-05
10 OHIP/ADM-3
10 OHIP/ADM-01

GISs 09 MA/027
08 MA/ 016
05 MA/033
05 MA/013

Interpretation: The A/R may spend down income to become eligible for Medicaid and also eligible for Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLIMB) however, the Medicare premium cannot be applied in whole or in part to reduce excess income. At the time of application, the applicant is encouraged to make a choice to apply the Medicare Premium to their spenddown to attain Medicaid eligibility **OR** to forego Medicaid eligibility for eligibility in the Medicare Savings Program. The advantages and disadvantages of both programs must be fully explained. An A/R may switch between spenddown and Medicare Savings Program***;*** however, in the interest of accuracy and administrative efficiency, the A/R is encouraged to select and remain in one of the two programs.

Eligibility for the MSPs must be determined even if an applicant does not indicate that he or she is applying for the MSP on the DOH-4220 or LDSS-2921.

NOTE: The ACCESS NY Supplement A does not have to be completed if the person is applying for MSP only.

There are four groups that are eligible for payment or part-payment of Medicare premiums, coinsurance and deductibles, through the Medicare Savings Program.

NOTE: See **REFERENCE** MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS for a chart displaying the Medicaid Levels and Federal Poverty Levels.

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If applicants are applying for MSP only they may complete DOH-4328 (Medicare Savings Program Application). There is no resource test for persons applying solely for MSP and who are not Qualified Disabled and Working Individuals (QDWI). However, if they are also applying for Medicaid with a spenddown, or they do not know what program to apply for, they must apply using the DOH-4220.

The Low Income Subsidy (LIS) program, also known as "Extra Help", is 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. (See **RESOURCES** THIRD PARTY RESOURCES) Section 113 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) states that an application to SSA for the LIS program for Medicare Part D benefits will be used to initiate an application for benefits under the MSP.

To comply with this requirement, upon receipt of a file from SSA, the State will provide information to local social services districts (ldss) to process eligibility for MSP benefits. Eligibility must be determined within 45 days of the date of application. In some instances, additional time may be required to process the application due to a delay on the part of the applicant to provide information or due to an administrative or other emergency beyond the district's control. The reason for the delay must be noted in the case record. The 45 day time limit for processing applications sent to the State from SSA begins the date the State receives the file from SSA.

NOTE: The Buy-In effective date may not precede the Medicare coverage effective date.

If the individual has lost Medicare eligibility a denial notice must be sent.

If an applicant on the LIS file qualifies for payment of their Medicare Part A premium through the Part A Buy-In program, a QMB case must be opened and an acceptance notice sent. If the applicant is not eligible for payment of their Part A premium, the case must be denied for MSP and a denial notice sent.

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MEDICARE SAVINGS PROGRAM

APPLICANTS WITHOUT AN ACTIVE OR PENDING MEDICAID CASE:

For applicants who do not have an active or pending case in WMS, the State will pre-populate and create an electronic copy of DOH-4496. A "Medicare Savings Program Request for Information" and a "Request for Information Cover Letter", OHIP-0035 must be mailed to the applicant. Forms returned to the ldss must be processed in the same manner as any other MSP application. If an applicant does not return the "Medicare Program Request for Information" by the requested date, OHIP-0036 "Notice of Denial for the Medicare Savings Program (Application received by SSA)" must be sent.

The application date for MSP eligibility for records sent to the ldss from the SSA LIS file is the date the individual applied for LIS at SSA. Eligibility for individuals who are determined eligible for SLIMB or the QI program may begin three months prior to the date of application. Retroactive coverage for the QI program cannot pre-date the current calendar year. For the QMB program, eligibility begins the month following the month of application. Eligibility for MSP can never begin earlier than the first month of Medicare eligibility, regardless of the date of application for MSP benefits.

Should the applicant indicate that they would like to apply for full Medicaid benefits, the applicant must be sent and must complete the Access NY Health Care application and comply with all current procedures for applying for Medicaid benefits.

NOTE: If after receiving a completed "Medicare Savings Program Request for Information" form it becomes apparent that the applicant lives in another district, the individual's information should be transferred to the appropriate ldss following current protocols.

APPLICANTS WITH AN ACTIVE OR PENDING MEDICAID CASE:

An eligibility determination must be made for cases where the individual is not on MSP, but has an active Medicaid case and is participating in the Excess Income Program, or is only eligible for Medicaid with no spenddown by using the Medicare premium as a deduction. If the applicant is eligible for MSP, the ldss must send OHIP-0037, "Option to Receive Medicare Savings Program (MSP) Benefit", and allow the individual to indicate his/her choice between spenddown and MSP eligibility. This form must be sent with the LDSS-4038, "Explanation of the Excess Income Program. This choice

must be offered to the individual even if the individual previously state his/her selection. If the individual fails to return the "Option to Receive Medicare Savings Program (MSP) Benefit", the case must remain open and benefits continued unchanged. An MSP denial notice must be sent to the individual if, after reviewing the record, it is determined the applicant is not eligible for MSP. A denial notice is not sent in instances where the individual does not return the form.

The application date for MSP eligibility is found on the ldss' LIS list located on the Human Services Enterprise Network (HSEN). The date is located in the field labeled "APP DATE". If determined eligible, benefits under the MSP begin on the date the person applied for LIS, or three months prior to that date if otherwise eligible. Benefits under the QMB category can only be provided the month following the month of application.

NOTE: If the individual is fully eligible for Medicaid without using the Medicare premium as a deduction and is eligible for MSP, the individual must be enrolled in the correct MSP category, and provided with appropriate notice.

If the individual is currently enrolled in the Family Health Plus program and the ldss finds that the individual is enrolled in Medicare, the ldss must follow current protocol for disenrolling the individual from FHPlus and determining eligibility for other programs such as MSP and Medicaid.

Individuals who have a pending application for MSP with the ldss, the application date for MSP shall be the earlier of the two application dates.

CATEGORICAL FACTORS

MEDICARE SAVINGS PROGRAM

Qualified Medicare Beneficiaries (QMBs)

The A/R must:

1. be entitled to benefits under Part A of Medicare; and

2. have income equal to or less than 100% of the federal poverty level.

If the A/R meets the above criteria, s/he is eligible for Medicaid payment of the Medicare Part A and B premiums, coinsurance and deductible amounts.

Specified Low-Income Medicare Beneficiaries (SLIMBs)

The A/R must:

1. have Part A of Medicare; and

2. have income greater than 100% but less than 120% of the federal poverty level.

If the A/R meets the above criteria s/he is eligible for Medicaid payment of the Medicare Part B premiums.