MEDICARE RIGHTS CENTER

Getting Medicare right

New York Medicare enrollment project tip sheet

Back-log notice recipients

On October 24, New York State released an Administrative Directive (ADM) to provide information and guidance regarding the requirement that certain Medicaid applicants/recipients apply for Medicare as a condition of their Medicaid eligibility. Now, new Medicaid applicants, individuals renewing their Medicaid, and others **must submit proof of Medicare application to receive/maintain their Medicaid**.

Starting December 15 in New York City and November 12 in the rest of the state, Local Departments of Social Services (LDSSs) will begin outreach to individuals in a "back-log" category. This includes people with Medicaid who:

1. Are age 65 plus two months or older
2. Meet Medicare eligibility requirements but have no parts of Medicare
3. Are not in a Medicaid renewal cycle
4. And, have incomes at or below the Medicare Savings Program (MSP) SLMB level.

These individuals will receive mailed notices explaining that **they must enroll in Medicare** to continue receiving their Medicaid benefits (see page 3 of this tip sheet for a sample notice).

The Medicare Rights Center has been told that 5,500 NYC mailings were sent in December and January, and 7,400 mailings were sent in November throughout the rest of the state. NYC mailings will be sent in three phases of similar sizes, and will eventually be shared with a total of 15,000 people.

Most notice recipients are likely ineligible for Social Security retirement (SSRI) benefits. This means that they are also ineligible for premium-free Medicare Part A and would normally have to pay the monthly Part A premium (up to $422 per month in 2018). However, the ADM explains how these individuals can keep their Medicaid and fulfill the Medicare enrollment requirement without paying for the Part A premium. What follows is a summary of how SSRI-ineligible individuals with Medicaid should apply for Medicare.

1. Medicare applicants must go in person to their local Social Security Administration (SSA) office. They can make an appointment over the phone (800-772-1213) or visit the office without an appointment.
2. The individual should gather the following materials to apply for Medicare:
    1. Proof of date of birth (copy of birth certificate)
    2. Proof of all types of income, earned and unearned (e.g., pay stubs, pension statements, tax returns)
    3. Proof of U.S. citizenship or lawful residence (e.g., passport, permanent resident card)
    4. And, a copy of their Social Security card and their Medicaid card
3. The individual should tell the SSA agent that they receive Medicaid, allowing them to enroll in Medicare outside an enrollment period (see page 4 of the ADM).
4. Individuals ineligible for premium-free Part A, with incomes equal to or less than 100% of the federal poverty level (FPL) ($1,025 for a single person and $1,229 for a couple), should:

[1]If eligible for premium-free Part A, an individual can enroll in Part A at any time and send proof of enrollment to their LDSS.

- Ask to enroll in Medicare Part B and conditional Part A.[1] For more information on this process, known as the Part A Buy-In, see Medicare Rights' flier, which includes relevant SSA Program Operation Manuals (POMS) citations. Applicants should bring the flier with them to the SSA office.
- These individuals will ultimately, if eligible, be enrolled in Part A, Part B, and the QMB MSP, which pays their Part A and Part B premiums.

5. Individuals ineligible for premium-free Part A, with incomes between 100% and 120% of FPL ($1,026-$1,226 for a single person and $1,230-$1,644 for a couple), should:
   - Ask to enroll in Part B only.
     - These individuals are not eligible for the QMB MSP. To avoid a Part A premium, they can avoid enrolling in Part A and enroll in Part B only.
   - Individuals can use their Part B premium to reduce their Medicaid spend-down.
     - The Part B premium ($134 per month in 2018) can lower an individual's countable monthly income for Medicaid, lowering their spend-down as a result and making it easier to access Medicaid.
   - New York State does not anticipate many individuals will meet these particular standards, and expect most "back-log" individuals will be eligible for QMB.
6. The SSA agent should provide applicants with a confirmation letter, also considered a receipt. This receipt serves as proof of enrollment in Part B and, if applicable, conditional Part A. **It is crucial for individuals to get this proof, because it must be submitted to their LDSS.**
7. Individuals should send a copy of their receipt to their LDSS as proof of Medicare application. Instructions related to submitting this receipt are included in the notice they received about needing to enroll in Medicare.
8. To complete the Medicare enrollment process and begin receiving premium-free Medicare (where possible), individuals can go to their LDSS and request to be put on the Buy-In. However, even if an individual does not actively request enrollment in the Buy-In/MSP at their LDSS, their returned proof of Medicare application should trigger MSP/Buy-In enrollment (see page 15 of the ADM).
   - Individuals with incomes equal to or less than 100% of the FPL, if eligible, will receive the QMB MSP, Part A Buy-In, and Part B Buy-In.
   - Individuals with incomes between 100% and 120% of FPL will not receive the Buy-in, but they will have Part B, and NYS may be able to assist with the Part B premium for those not eligible for QMB.

Individuals who do not provide proof of their Medicare application will be scheduled to lose their Medicaid benefits. These individuals will receive a closing notice approximately 45 days after they receive the original back-log notice. The closing notice should include fair hearing rights. **Medicare Rights has been told that 4,000 people outside of NYC lost their Medicaid effective December 31, 2017, because they did not contact their LDSS after receiving the back-log notice and provided no proof of Medicare application.**

Individuals can request a fair hearing and, if they request one soon enough, can ask for aid continuing. An approved aid continuing request allows an individual's Medicaid benefits to continue while their fair hearing is pending.

- If an individual's fair hearing is unfavorable, they could be asked to pay back their Medicaid benefits from the time of their case closing. It is important that individuals apply for Medicare, as described in the ADM, to ensure that Medicaid coverage is not lost or interrupted.
- **Important: Individuals can request an extension to submit proof of their Medicare application if they cannot obtain coverage by the deadline**. For more information, see page 8 of the ADM for individuals living upstate and page 13 for individuals living in NYC.

Individuals who need more time to apply for Medicare can request an extension. They can do so by contacting their LDSS/HRA.
HRA created a form allowing individuals to request an extension (MAP-3062c). The form allows the beneficiary to attest that they are unable to provide the documentation at this time and to request "additional time past the deferral due date that HRA provided." The form requires the individual to explain why they require the extra time. HRA will inform the individual if they are approved for an extension. See page 7 for a copy of the extension request notice and form.

Individuals who submit inadequate or inaccurate proof may receive a deferral notice, giving them additional time to provide the proof needed to keep their Medicaid case open. For more information, see page 13 of the ADM.

If you have questions, please contact the Medicare Rights Center at 800-333-4114.

CNS Paragraph Form

Date: 08.21.2017

Program Area	03	(01=PA, 02=FS, 03=MA, 04=HP)
Paragraph Number	S0036	
Version Number	00001	
Effective Date	2017	
Title	Over 65, Request to Apply for Medicare	
Comment	Used for "backlog" NYC	
Reason Code	MCB	

Name Client I.D. #

Our records indicate that you are 65 years of age or older and do not have MEDICARE. When you turn age 65, you are required to apply for MEDICARE as a condition of eligibility for Medicaid.

In order to continue to be eligible for benefits under the Medicaid program, you must apply for MEDICARE coverage if it is available to you.

You must apply by calling the Social Security Administration at 1-800-772-1213 or by applying on-line at: https://www.ssa.gov/medicare/.

You have until _____ to apply for Medicare and send us proof that you applied.

Proof can be:

- Your award or denial letter from the Social Security Administration, **OR**
- Your online confirmation letter stating that you have applied for MEDICARE with the Social Security Administration

Proof should be returned in the self-addressed stamped envelope included with this letter.

What is the difference between MEDICARE and Medicaid?

- **MEDICARE** is a federal program that gives you health care coverage if you are 65 or older regardless of your income. You may now be entitled to additional medical benefits through the MEDICARE program.
- **Medicaid** is a State-run program that covers medical expenses for people with low or limited incomes.

When a person has both MEDICARE and Medicaid, MEDICARE pays first and Medicaid pays second. Individuals with MEDICARE also have more medical providers to choose from.

There are Medicaid programs that may help you with your MEDICARE premium costs and prescription drug costs.

The MEDICARE Savings Program (MSP) helps pay the MEDICARE premiums. If you are eligible for the MEDICARE Savings Program, Medicaid will pay the cost of your MEDICARE premiums. This program has higher income levels than the Medicaid program and, also has no resource test. To find out if Medicaid can pay your MEDICARE premiums, contact the NY State of Health or your local Depart-

ment of Social Services. If you live in New York City you can call 311 to find an office near you.

- The MEDICARE Prescription Drug Program (Medicare Part D) is the part of MEDICARE that provides prescription drug coverage. If you are determined eligible for MEDICARE, you will receive more information from the Centers for MEDICARE and Medicaid Services (CMS) about what you need to do to join the MEDICARE Prescription Drug Program (Part D), how MEDICARE will help pay for your drug costs, and what other steps you will need to take. It is very important that you keep this information and read it carefully. If you have any questions regarding MEDICARE, call 1-800-633-4227. For free, personalized counseling regarding your MEDICARE plan choices and benefits, call The Health Insurance Information Counseling and Assistance Program (HIICAP) at 1-800-701-0501.

Apply for MEDICARE Today

This notice is based on Section 366 (2)(b)(1) of the Social Services Law.

~S/

Nombre No. del I.D. del Cliente

Nuestros registros indican que tiene 65 años de edad o más y que no tiene MEDICARE. Cuando cumpla 65 años, debe solicitar MEDICARE como condición de elegibilidad para recibir Medicaid.

Para seguir siendo elegible para recibir los beneficios conforme al programa de Medicaid, debe solicitar la cobertura de MEDICARE si está disponible para usted.

Para realizar la solicitud **debe** llamar a la Administración de Seguro Social al 1-800-772-1213, o realizar la solicitud en línea accediendo a: https://www.ssa.gov/medicare/.

Tiene tiempo hasta el _____ para solicitar Medicare y enviarnos un comprobante de su solicitud.

El comprobante puede ser:

- Su carta de adjudicación o denegación de la Administración de Seguro Social, O
- Su carta de confirmación en línea que indique que usted ha solicitado MEDICARE ante la Administración de Seguro Social

Debe enviar el comprobante en el sobre prefranqueado con el domicilio del destinatario que se incluye con esta carta.

¿Cuál es la diferencia entre MEDICARE y Medicaid?

- **MEDICARE** es un programa federal que le proporciona cobertura de atención médica si tiene

65 años o más, independientemente de sus ingresos. Es posible que ahora tenga derecho a recibir beneficios médicos adicionales a través del programa de MEDICARE.
- **Medicaid** es un programa dirigido por el estado que cubre los gastos médicos para las personas con ingresos bajos o limitados.

Cuando una persona tiene MEDICARE y Medicaid, MEDICARE paga primero y Medicaid paga en segundo lugar. Los individuos con MEDICARE también tienen más proveedores médicos para elegir.

Existen programas de Medicaid que pueden ayudarle con los costos de sus primas de MEDICARE y con los costos de sus medicamentos recetados.

El Programa de Ahorros de MEDICARE (MSP) lo ayuda a pagar las primas de MEDICARE. Si es elegible para el Programa de Ahorros de MEDICARE, Medicaid pagará el costo de sus primas de MEDICARE. Este programa permite niveles de ingresos más altos que el programa de Medicaid y además no tiene evaluación de recursos. Para descubrir si Medicaid puede pagar sus primas de MEDICARE, comuníquese con el NY State of Health o con su Departamento de Servicios Sociales local. Si vive en la ciudad de Nueva York, puede llamar al 311 para buscar una oficina cercana a su domicilio.

- El Programa de Medicamentos Recetados de MEDICARE (Medicare Part D) es la parte de MEDICARE que proporciona cobertura de medicamentos recetados. Si se determina que usted es elegible para MEDICARE, recibirá más información de los Centros de Servicios de MEDICARE y Medicaid (CMS) acerca de lo que debe hacer para formar parte del Programa de Medicamentos Recetados de MEDICARE (Part D), de qué manera MEDICARE pagará los costos de sus medicamentos y qué otros pasos deberá tomar. Es muy importante que guarde esta información y la lea detenidamente. Si tiene alguna pregunta con respecto a MEDICARE, llame al 1-800-633-4227. Para recibir asesoramiento personalizado y gratuito con respecto a las opciones de planes y los beneficios de MEDICARE, llame al Programa de Información, Asesoramiento y Asistencia sobre Seguros de Salud (HIICAP) al 1-800-701-0501.

Solicite MEDICARE hoy mismo

Esta decisión se basa en la Sección 366 (2)(b)(1) de la Ley de Servicios Sociales.

REQUEST FOR A TIME EXTENSION:
MEDICARE APPLICATION

NYC Human Resources Administration
Department of Social Services

MAP-3062c 12/13/2017

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.

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