



## APPLE HEALTH (MEDICAID) MANUAL REVISION

<b>Revision #</b>	<b>022</b>
<b>Chapter / Section</b>	<b>Long term Care – Medicare and LTC</b>
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<http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/medicare-and-long-term-care>

Medicare and Long Term Care

### Summary of Revision

HCA clarification regarding the start date of S03/Medicare Savings Program for client's that become eligible or receiving LTC.

Added additional clarification regarding Medicare co-insurance days.

Added information on non-contracted Medicaid nursing facilities what are contracted for Medicare.

Change in the Medicare Savings Program effective date. If the applicant is applying for LTC, the effective date is based on the date all verifications needed to establish eligibility are received rather than based on the LTC start date if LTC eligibility is driving the S03/QMB eligibility.

Added information that if an active Medicaid client subsequently becomes eligible for medicare, we will screen in the QMB the month prior so the QMB opens in the same month as the medicare.

## Apple Health (Medicaid) Manual revision via track changes:

URL: <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/medicare-and-long-term-care>

# Medicare and Long-Term Care

Revised ~~October 21, 2014~~ put date here

**Purpose:** This section includes the link to Medicare programs. ~~This section and~~ includes additional information relating to Medicare and long-term care programs. Long-term care programs are defined as residing in a medical institution 30 days or more or one of the HCS or DDA Waiver programs.

## Medicare Programs

[Medicare Programs](#) ~~describes has the WAC and clarifying on~~ Medicare and Medicare Savings Programs (MSP). ~~Please refer to this section for a complete description of Medicare programs.~~

[Medicare Savings Program \(MSP\) Certification periods](#)

[Medicare information from the Washington State Office of the Insurance Commissioner](#) (includes information on the different types of Medicare, Medicare supplement (called Medi-GAP) plans in Washington and Medicare C Advantage Plans in Washington along with the SHIBA help line.

**Note:** A client receiving both Medicare and Medicaid is called a full benefit dual eligible (FBDE)

[Medicare Savings Programs – Reference guide](#) – ~~Desk aid describes the medical coverage groups and QMB, SLMB, QI-1, ODWI and state buy-in programs.~~

Commented [RL(1)]: <https://www.hca.wa.gov/assets/free-or-low-cost/MSP-desk-aid.pdf>  
link to this chart

## Railroad Retirement

Railroad Retirement Medicare entitlement is NOT in SOLQ. The ~~individual-client~~ can present a Red, White and Blue Medicare entitlement card or RRB approval or award letter that shows ~~their individual's~~ or ~~their~~ dependent's Medicare coverage. RRB award letters do not provide entitlement dates for Part A and Part B. The RRB Red, White and Blue cards do provide Medicare entitlement dates.

The number for Railroad Retirement Medicare Benefits is: 1-877-772-5772. Railroad retirement field office locator: <https://www.rrb.gov/field/field.asp#ziplocator>

**Commented [RL(2)]:** Link to the railroad board.gov website:  
<https://secure.rrb.gov/>

Do not complete Medicare TPL screens for individuals receiving Medicare under Railroad Retirement. The Medicare buy-in unit must code screens for Railroad Retirement. Send a barcode tickler to [102@MBU](mailto:102@MBU) requesting the TPL screens be completed as Medicare is under railroad retirement.

## Medicare buy-in unit

For Medicare Buy-in issues contact: 1-800-562-3022 Ext.1-6129. This phone number is strictly for Medicare premium payment questions only.

You can contact the Medicare Buy in unit on a case related question by using a barcode tickler to [102@MBU](mailto:102@MBU)

## Medicare information specific to long-term care

Medicare payment for nursing facility cost of care:

- Medicare pays the full cost of care for NF services for up to 20 days per benefit period and partial costs for the remainder of 100 days when the individual-person meets Medicare requirements. The partial costs is called Medicare A co-insurance days.
- If the individual-FBDE enters the NF under Medicare coverage, the agency determines eligibility and participation the same as for any other institutional individual person on medicaid. Do not code Medicare days in ACES (ME) as this will affect the NF award letter.
- The individual-FBDE does not pay participation toward Medicare days, but does pay participation toward Medicaid days. Participation is a post-eligibility requirement tied to institutional medicaid programs, not the medicare benefit.
- Monitor resource eligibility when an individual-FBDE is on full Medicare days. A Medicare/Medicaid individual-FBDE on Medicare for the full 100 days who does and not having a pay participation responsibility may have acquire excess resources, on the 1st day of the month during this period. Medicare Coverage of Skilled Nursing Facility Care explains the NF medicare benefit.

**Commented [RL(3)]:** <https://www.medicare.gov/pubs/pdf/10153.pdf> Add this link here.

## Reimbursement Rates for ~~Medicaid Clients~~ full benefit dual eligibles (FBDE) ~~enrolled in Medicare~~

Purpose: This clarification is based on the Dear Nursing Home Administrator letter NH #2010-001 sent 3/26/2010.

For Medicaid clients enrolled in fee for service Medicare (not Medicare Advantage plans), Medicare will pay in full for up to the first twenty days of nursing facility care at the full Medicare rate. For the first day and up to eighty days thereafter (i.e. the hundred and first day), the amount paid by Medicare will be reduced by the client's co-insurance responsibility. The agency will pay up to the Medicaid rate for the co-insurance days. This is described in WAC [182-502-0110](#) (3) and WAC [182-517-0320](#) (1) and [1902 of the Social Security Act](#)

## Reimbursement rates for Qualified Medicare Beneficiaries (QMB) ~~only clients~~

~~Those eligible for QMB-only clients are not eligible for Medicaid under the categorically needy (CN) or medically needy (MN) programs, but~~ are eligible for payment of Medicare cost sharing expenses.

**Note:** A QMB only client may apply for a CN or MN program if Medicaid is needed beyond the Medicare days in the nursing facility.

QMB is medical coverage group S03 in ACES.

The agency will pay for Medicare co-insurance charges for QMB-~~only~~ residents, up to the Medicaid nursing facility reimbursement rate. It will not be necessary for a QMB-only resident to apply for Medicaid services for payment of co-insurance expense during Medicare coinsurance days. QMB-only clients are not required to pay participation. They will not be issued a Medicaid award letter. An award letter is not required in order to bill the agency for ~~these Medicare co-payment~~ expenses. Providers should refer to the nursing home billing guide for instructions on how to bill for QMB-only claims: [Nursing Facilities Billing Instructions \(Provider Guides\)](#)

## Reimbursement rates for ~~Medicaid clients~~ FBDE enrolled in Medicare Part C (Advantage) plans

For Medicaid clients enrolled in Medicare Part C plans, payment for Medicare days including co-insurance days may vary depending on the Medicare C plan. The agency will pay up to the Medicaid rate for co-insurance days.

## Medicaid client participation during Medicare days including co-insurance days

Facilities may not collect participation from Medicaid clients during Medicare days, including Medicare co-insurance days. Client participation which is indicated on the [DSHS-nursing facility](#) Medicaid award letter is only applicable for Medicaid days.

Client participation is not an eligibility factor for Medicare coverage. This includes cases where the Medicaid rate is higher than the Medicare co-insurance rate and DSHS is billed for the co-insurance up to the Medicaid rate. Clients or their representatives are responsible to report if their resources exceed Medicaid standards when clients are in Medicare status as they are not participating their monthly income toward the cost of care during Medicare days.

**Note:** The agency cannot use Medicaid funds to pay the recipient's co-insurance responsibility beyond the amount Medicaid would pay for the service and cannot allow nursing facilities to write off the unpaid amounts as bad debts on their Medicaid cost reports.

Nursing Home Providers may contact the nursing home claims processing unit at the Health Care Authority (HCA) with questions regarding the billing during Medicare days.

### Non-contracted Medicaid nursing facilities

Some nursing facilities are contracted with Medicare, but not with Medicaid. Nursing facilities can file a Medicare co-insurance claim with HCA for QMB eligibles.

If the Medicare days end, the nursing facility cost would be considered private pay. If the person remains in a non-contracted Medicaid, the only program that can be considered is a S99. A private pay cost in a medical institution is an allowable spenddown expense.

If a client is on HCB Waiver and that is what is driving the S03/QMB eligibility, and enters a non-Medicaid contracted Medicare facility, a redetermination will be needed if the client is in the NF 30 days or more under the S99 program. This redetermination will likely cause the S03/QMB to close after the 10 day notice period.

## Medicare premiums as a participation deduction

Only out of pocket Medicare premiums are an allowable participation reduction. If the Medicare premium is covered under a Medicare savings program (MSP) or state buy-in, it is not an allowable participation reduction. Consult the allowable medical services and expenses used to reduce participation in the Apple Health eligibility manual for complete information on medical expenses used as a participation reduction.

Commented [RL(4)]: <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/allowable-medical-expenses> link here.

All FBDE individuals are automatically enrolled in the LIS/Extra help subsidy for Medicare D [prescription drug coverage](#) unless the individual has creditable coverage for prescriptions under another plan. If a LTC elects to have a non-benchmark Medicare D plan, the out of pocket cost (difference in the premium minus the LIS subsidy) is an allowable medical expense deduction from participation. For new LTC clients that have these non-benchmark premiums, the FSS should monitor when LIS subsidy begins for client and update the deduction in ACES. This can be monitored for when the PDP or MA-PD premium is deducted from SSA, by checking SOLQ and cross-match with SHIBA plan guides.

SHIBA link for PDP plans: <https://www.insurance.wa.gov/your-insurance/medicare/prescription-drug-coverage-d/part-d-cost-cover/>

SHIBA link for MA-PD plans: <https://www.insurance.wa.gov/your-insurance/medicare/medicare-advantage-plans-c/ma-plans-by-county/>

Any expense deducted from room and board (residential individuals in ALFs) is coded as an ETR. Signed ETRs are needed to deduct any expense from room and board. Do not request an ETR if there is available participation.

~~See [allowable medical expenses for a complete description of expenses that can be used to reduce participation](#).~~

## Medicare D-Prescription Drug Plan

Beginning January 1, 2006, Medicare assumed responsibility for the prescription drug coverage for over 6 million low-income Medicare beneficiaries who are also enrolled in Medicaid. These beneficiaries are referred to as full-benefit dual eligible (FBDE). They qualify for Medicare prescription drug coverage with no premiums. There are several Prescription Drug Plans (PDP) to choose from in Washington. Benchmark plans have no premium costs for Medicaid individuals. Benchmark plans are paid by Medicare under the low income subsidy (LIS) program. Medicare will provide prescription drugs for dual eligible individuals.

- All FBDE transitioned from Medicaid drug coverage to Medicare drug coverage as of January 1, 2006.
- FBDE receive their prescriptions through a Prescription Drug Plan (PDP) unless they receive prescriptions through a creditable coverage plan. If they do not enroll in a plan, they are automatically assigned a PDP. The assignment is random.
- FBDE can change plans any time [by contacting 1-800-Medicare](#). ~~and~~†The new plan will be effective the first of the next month.
- Medicaid will continue to cover some drugs not covered in Part D including over-the-counter medications [that are specifically listed on the HCA website](#).

- FBDE have co-pays under Medicare Part D that will vary.
- FBDE on a benchmark Medicare D plan have their premiums paid by the low income subsidy (LIS) program through Medicare.
- FBDE are entitled to premium-free Part D enrollment, however they may elect enrollment in an enhanced plan. Those who enroll in an enhanced plan are responsible for the portion of the premium attributable to the enhancement and that portion is an allowable deduction in the post-eligibility calculation.
- FBDE residing in institutions (nursing homes and ICF-MRs) are exempt from Med D co-pays once they are residing in a facility for a full calendar month. A FBDE will have no Med D co-pays once they are deemed in a medical institution through the end of the calendar year. This group is called LIS 3.
- FBDE eligible for a Home and Community Based Waiver are exempt from Med D copayments starting 1/1/2012. Starting 1/1/2012 a FBDE are deemed in the institutional group called LIS 3 through the end of the calendar year.

**Example:** FBDE is on ~~COPES-Community First Choice (CFC)~~ 2/1/2011, on 2/28/2011 the individual enters the NF. On 5/3/2011 the individual returns home on ~~COPES CFC~~. For this individual, the Medicare D co-payments end on 4/30/2011 and will continue to have no copayments through 12/31/2011 (the end of the calendar year).

**Note:** Medicare D co-payments ended for home and community based (HCB) waivers effective 1/1/2012 due to federal legislation. A pharmacy is required to accept at HCB Waiver award letter from ACES or a Planned Action Notice (PAN) from the social service authorization for new HCB Waiver openings until the interface between ProviderOne and Medicare identifies the HCB Waiver person as LIS 3 in the system.

## Medicare D payment levels and what they mean.

Health Care Authority (HCA) sends information to Centers for Medicare and Medicaid Services (CMS) regarding a FBDE status. CMS sends this information to the PDP.

Payment level 1: QMB, SLMB only

Payment level 2: FBDE individual not institutionalized

Payment level 3: Institutional group. Effective 1/1/2012 this will include ~~Home and Community based HCB~~ waiver eligibles authorized by ~~DDDA~~ or HCS.

If the PDP indicates to the pharmacy that ~~an individual person~~ is still not showing up as a payment level 3, the individual must present an award letter or PAN showing institutional medical eligibility as "best available evidence" in order for the Medicare D co-payments

to be waived. ~~A social service planned action notice (PAN) showing institutional or waiver eligibility can also be used.~~

If the ~~individual~~ person in an institution or on a HCB Waiver still shows up as a payment level 2 even after the PDP has received an institutional award letter, the pharmacy or PDP should contact ~~CMS Region 10 in Seattle~~ 1-800-Medicare.

Field staff or the HCB Waiver client can call 1-800-Medicare (1-800-633-4227) to report any issues around Medicare D or complaints about the PDP or a pharmacy not accepting an award letter or planned action notice. If a complaint is made to Medicare, a copy of the complaint will be forwarded to CMS. It also tracks the complaints to make the PDPs accountable for customer service.

For HCS individuals, refer the issue to the Regional Financial Program Manager to forward to CMS Region 10 contact if the pharmacy or PDP does not accept the Best Available Evidence (BAE) institutional award letter or PAN and a prescription is needed right away.

Include the individual's name, client ID, pharmacy and PDP if known. Indicate the type of BAE presented in order to get the individual's payment level changed to a 3.

#### [HCA Medicare Part D Resources](#)

#### [Drugs Covered by Medicaid](#)

The Medicare D benchmark plan is the maximum monthly premium that will be paid by CMS for persons qualifying for "Extra Help". If a person receiving the low-income subsidy (LIS) enrolls in a Medicare Part D plan which has a premium higher than the amount listed as a benchmark, the beneficiary is responsible for paying the difference in the premium.

All Medicaid individuals are automatically enrolled in the LIS/Extra help subsidy. If an LTC individual elects to have a non-~~-~~benchmark plan, the out of pocket cost (difference in the premium) is an allowable medical expense deduction from participation.

## Medicare D Prescription Drug Plan for newly Medicaid eligible

Until a FBDE individual is auto enrolled in a Medicare D prescription drug plan, newly eligible Medicaid individuals get their prescription drugs through the [Limited Income Net Program](#) (LI-NET) powered by Humana.

**Note:** Medicare D premiums are paid by Medicare's low income subsidy (LIS) program



not HCA. HCA sends information on all Medicaid recipients eligible to receive Medicare benefits to Medicare in order for Medicare to enroll these individuals in the low income subsidy program. Benchmark plan premiums are covered 100% by the Medicare LIS program. Individuals need to call **1-800-Medicare** if they wish to switch to a benchmark plan. Individuals need to call their PDP plan to resolve issues with prescription drug coverage.

HCA does not enroll individuals in Medicare D plans, this is done by Medicare.

## Creditable coverage and Medicare D

Not all Medicare eligible individuals have Medicare D. Individuals that have "creditable coverage" are not required to enroll into a Medicare D plan once they become Medicaid eligible.

### What is creditable coverage?

Creditable Coverage Definition and Determination defined by CMS:

As defined in the regulation at [42 CFR §423.56\(a\)](#), drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage. In general, this actuarial determination measures whether the expected amount of paid claims under the entity's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit. [See 70 CFR 4225](#)

In other words, if an individual has a health insurance that includes comparable prescription drug coverage, they do not have to enroll into a Medicare D plan.

These plans are required to send a document to the individual indicating they provide comparable prescription drug coverage.

Refer individuals to the Washington State Office of Insurance Commissioner (SHIBA) if individuals have questions about switching insurance.

### Do individuals have out of pocket prescription drug co-payments associated with creditable coverage plans?

Yes. Creditable coverage plans may have co-payment charges that are considered out of pocket costs to the individual. These out of pocket costs must be verified in order for the agency to reduce participation. Once the agency has verification of what the health

insurance has paid toward the prescription drugs, the out of pocket co-payment is an allowable deduction from participation.

**What happens if the system automatically enrolls an individual with creditable coverage into a Medicare D prescription drug plan once they become eligible for Medicaid?**

The individual or their representative will need to contact 1-800-Medicare and their creditable coverage insurance carrier to indicate they want to retain their creditable coverage health plan. There are times when Medicaid individuals are enrolled into a Medicare D PDP incorrectly when the individual has creditable coverage.

## **Clarification from Centers for Medicare and Medicaid Services (CMS) issued 12/2005 regarding Medicare D prescription drug costs and post eligibility.**

Beginning January 1, 2006 individuals enrolled in Medicare will be able to receive prescription drugs through Medicare Part D. For the most part, coverage of prescription drugs will no longer be available under Medicaid. Many states have raised questions about how to treat pharmacy charges and Part D costs for institutionalized individuals.

### **Part D Premiums**

Full benefit dual eligibles (FBDEs) are entitled to premium-free Part D enrollment, however they may elect enrollment in an enhanced plan. Those who enroll in an enhanced plan are responsible for that portion of the premium attributable to the enhancement. When an institutionalized FBDE is enrolled in an enhanced plan the portion of the premium that remains the individual's responsibility is an allowable deduction in the post-eligibility calculation.

### **Co-pays, Deductibles & Coverage Gap**

Full benefit dual eligibles (FBDEs) who are institutionalized and enrolled in a Part D plan or a Medicare Advantage-Prescription Drug plan (PDP or MA-PD) will not be responsible for the payment of deductibles or co-pays, nor will they be subject to a coverage gap in their Part D benefits (these rules do not apply to individuals eligible

under a 1915 (c) waiver). Listed below are the various circumstances that may apply to institutionalized FBDEs:

1. The plan will require no co-pays or deductibles and will apply no coverage gap.
2. If the state identifies the individual as an institutionalized FBDE for past months on their monthly MMA file, the plan will reimburse the individual for any co-pays incurred during those months.
3. If the state identifies the individual as an institutionalized FBDE for past months on their monthly MMA file, the plan will reimburse the individual for co-pays, deductibles and costs incurred during a coverage gap for those months.
4. The plan will be responsible for drug charges with the effective date of the enrollment. The plan will not charge deductibles or co-pays, or apply a coverage gap to those enrolled as institutionalized FBDEs.

In the first three circumstances above, when post-eligibility is calculated, there should be no deductions for co-pays, deductibles or coverage gaps. This is because, if incurred, the individual is not ultimately responsible for these charges. In the last circumstance above, the individual will remain responsible for Part D covered drugs purchased prior to the effective date of the Part D enrollment. In this circumstance the cost of these drugs is an allowable deduction in the post-eligibility calculation.

## Non-formulary Part D Drugs

PDPs and MA-PDs are required to develop transition plans for institutionalized individuals. Plans may allow for limited coverage of drugs that are not part of the plan's formulary. Each PDP/MA-PD's transition plan may vary. Plans must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied. Part D drugs that are not covered by the plan may not be covered by Medicaid, and absent other drug coverage, these would remain the responsibility of the individual. These charges may be allowable deductions in the post-eligibility calculation. To determine whether or not prescription charges should be allowed in post-eligibility, apply the following rules:

1. When a plan denies coverage of a prescription the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the decision on any exception requested. If the drug charge appears on the statement as a denial, and no exception was requested, do not allow the charge.
2. If the drug charge appears on the statement as a denial, and an exception was requested and denied, allow the charge. At the state's option, the deduction for these costs may be subject to reasonable limits.

This procedure will help ensure that legitimate costs for drugs not covered by the plan are correctly allowed in post-eligibility. By relying on the plan statements and exception notices, eligibility workers will not need to be concerned with knowing the plan's formulary or non-formulary drugs covered under a transition plan or under the exception process. Applicants should be advised to maintain these documents for consideration in post-eligibility.

### Non-Part D Covered Drugs

Certain drugs are not covered under Part D. State Medicaid programs have the option of covering these excluded drugs. If the institutionalized FBDE presents documentation that a purchased drug is excluded under Part D, and the State Medicaid program has not opted to cover the drug, absent other drug coverage, the drug may be an allowable deduction in the post-eligibility calculation. States may place reasonable limits on this deduction.

### Projection and Reconciliation

For states that opt to project medical expenses for post-eligibility, note that the projected figures must be reconciled at the end of the prospective period. Use the guidelines above to determine the beneficiary's actual costs to determine the appropriate adjustment to the projected deductions.

**Note:** HCS Management Bulletin H06-015-Procedure dated March 7, 2006 includes several handout and Q and A regarding Medicare D.

## What about Medicare insurance supplements, also called MEDI-Gap plans?

Medi-Gap plans are private insurance supplements that provide additional coverage for certain Medicare co-payments.

Medi-Gap insurance premiums are an allowable post eligibility deduction from participation.

Medi-Gap insurance is not allowed as an ETR from room and board. The reason for this is because individuals in medical institutions or on a HCB Waiver are eligible to receive a Medicare Savings Program (MSP) which provides the same co-payment coverage as a Medi-GAP plan. Do not allow Medi-GAP insurance as a deduction from state-funded room and board.

Individuals can choose to cancel Medi-GAP plans when going on institutional and HCB

Waiver services and QMB. If the individual goes off Medicaid, they have 30 days per the Office of Insurance Commissioner to notify their Medi-GAP plan that they want to be reinstated. Refer [individual's clients](#) to their local SHIBA counselor if they have questions about cancelling and reinstating their Medi-GAP plans.

## Medicare C - Medicare Advantage Plans

Medicare Advantage plans are another way to get original Medicare (Parts A and B).

Medicare pays a private insurance company you select to manage your care.

You pay:

- Part A premiums (if any)
- Part B premiums
- The Medicare Advantage plan's premium (if any)
- Any deductibles, co-pays, or coinsurance

For individuals on institutional Medicaid, the only out of pocket expense would be the Medicare Advantage plan premium if any.

Since institutional Medicaid individuals receive both Medicaid and QMB Medicare savings program, the deductible and copayments are covered (up to the state rate). Providers with a Medicaid contract are to accept payment at the state rate.

### What do these plans cover?

All medically necessary care covered by original Medicare.

They **could** include prescription drug coverage (Medicare Part D)

They could include additional coverage for vision, hearing, dental, foot care.

For additional information on Medicare advantage plans including approved Medicare Advantage Plans in the State of Washington by county.

## Medicare Savings Program (MSP) and Long-term care. Effective date

**Note:** The date eligibility is established for QMB/S03 is based on the financial worker having all the information needed in order to make a decision on the application. HCA has clarified that QMB needs to be open the first of the following month the action could have been taken by the FW.

**QMB/S03** starts the first of the month following the date eligibility is established. If institutional eligibility is needed in order to open S03 because income is over the FPL, then the S03 opens the first of the month following the date all verification was received to establish institutional eligibility. The date eligibility is established is the date that is indicated on the VEF screen. HCA has given a clarification that if verifications is received, but LTC does not start until the following month, that the FSS would indicate the date the verifications are received on the VEF screen. If verifications were received in a prior month than the LTC start date, this would cause the S03 to open in the same month as the LTC. Even though the LTC eligibility is driving S03 eligibility, this is correct.

**S05/SLMB** starts in the month the individual is income/resource eligible for the program. This includes a retro month.

**S06/QI 1** starts in the month the individual is income/resource eligible for the program. This includes a retro month.

**What is a retro month?** A retro month is 3 months prior to the date the application was received.

**What is a plug in?** A plug in is needed when P1 does not pick up the eligibility from ACES. MPA-HCA indicates it is always needed for MSP or state buy in coverage in a retro month. To request a plug-in contact the Medicare buy-in unit using a barcode tickler to: [102@MBU](mailto:102@MBU)

**State buy-in.** This is state funded and picks up the Medicare B premium in the 3rd month of Medicaid eligibility. State buy in is used when the individual is not eligible for a federally matched MSP program but is eligible for a Medicaid program. State buy-in is frequently used for the HWD program and spenddown as most of these individuals have income that exceeds the MSP income standards.

If we are opening an institutional program back several months and an individual was not eligible for the S03/QMB until the first of the month following the month we had all the necessary information to open S03, the state will still buy in the Medicare premium in the 3rd month of eligibility.

**Active Medicaid client subsequently becomes eligible for Medicare** In this scenario, HCA has confirmed that the FSS would screen in the S03 in the month prior to the Medicare eligibility in order to start the MSP in the month the client becomes medicare eligible.

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**Note:** For more information, see [allowable medical expenses used to reduce participation](#)

## ACES-Medicare Savings Programs

LTCX screen coding and Medicare:

OA-Medicare Part A premiums

OB-Medicare Part B premiums

OC-Medicare Part C premiums

OD-Medicare Part D premiums

OP-Medicare Part D co-payments

## Additional helpful links for Medicare issues

[Statewide Health Insurance Benefits Advisors \(SHIBA\)](#)

[Medicare prescription drug program \(Part D\)](#)

[Medicare Website](#)

[Apply Online for Medicare](#)