

North Carolina Department of Health and Human Services
North Carolina Medicaid
Division of Health Benefits

AGED, BLIND, AND DISABLED MEDICAID MANUAL

MA-2410

MEDICARE ENROLLMENT & BUY-IN

REVISED 06/13/23 – CHANGE NO. 10-23

I. INTRODUCTION

A. What is Medicare?

Some Medicaid recipients are eligible for medical benefits from Medicare. Medicare is a health insurance program authorized by Title XVIII of the Social Security Act. It is administered by the federal Centers for Medicare and Medicaid Services (CMS) in Baltimore, Maryland. People who are age 65 or over, people under age 65 who have been entitled to disability benefits under the Social Security or Railroad Retirement program for 24 months, and some people with renal disease are eligible.

Medicare has four parts:

1. Part A, Hospital Insurance

Part A covers medically necessary inpatient hospital services and care in a skilled nursing facility after hospitalization. It also helps cover hospice care and some home health care.

2. Part B, Supplementary Medical Insurance

Part B covers medically necessary physician's services, outpatient hospital services, outpatient therapy and speech pathology services. It also covers other medical services such as laboratory, X-rays and medical supplies, and home health services when the individual does not have Part A.

3. Part C, Medicare Advantage Insurance

Part C allows beneficiaries to enroll in additional types of health plans, including managed care plans.

4. Part D, Medicare Prescription Drug Plan

Part D Medicare Prescription Drug plan covers both brand-name and generic prescription drugs at participating pharmacies.

(I.)

B. Medicaid Supplements Medicare Payments for Medical Services

For Medicaid recipients who are covered by Medicare, Medicare is the primary payor. This means that Medicare pays before Medicaid. Medicare pays the amount that it will pay for a service that it covers. If the service is covered by Medicaid and Medicare does not pay as much for the service as Medicaid pays or the Medicare payment is reduced by a deductible or co-payment, Medicaid pays for the portion of the cost of the service up to the Medicaid allowable that Medicare did not pay.

It is important that Medicaid recipients who are also eligible for Medicare are enrolled in Medicare. The Medicare payment reduces the amount that Medicaid must pay for the service. If a Medicaid recipient who is over age 65 is not enrolled in Medicare Part B, Medicaid does not pay any portion of services that would have been covered by Medicare Part B.

C. Medicaid will Pay Medicare Premiums

1. Most people who have Medicare Part A, Hospital Insurance, do not pay monthly premiums since they have credits for work under Social Security. Those who do not have work credits must pay a monthly premium. However, if the person is enrolled in Medicare Part B, Supplementary Health Insurance, and is eligible for Qualified Medicare Beneficiary Coverage (Q classification), Medicaid pays his Part A premium. (Refer to [MA-2130](#), Qualified Medicare Beneficiaries-Q.)
2. There is a monthly premium for Part B. The premium is deducted from the Social Security check, or billed quarterly to those persons who do not receive monthly Social Security benefits, but who qualify and are enrolled in Medicare Part B. Medicaid pays the Part B premium for Medicaid recipients eligible for Part B coverage.

The payment of Medicare premiums by Medicaid is referred to as the “Medicare Buy-In.”

II. WHO IS ENTITLED TO MEDICARE?

A. Aged Individuals

An individual who is age 65 or older, who resides in the United States and is:

1. A U.S. citizen, or
2. An alien who has lived in the U.S. continuously during the 5 years immediately preceding the month he applies for Medicare.

(II)

B. Blind and Disabled Individuals

A U.S. citizen under age 65 and entitled to disability benefits for at least 24 months under the Social Security or Railroad Retirement programs. This group includes:

1. Disabled workers at any age.
2. Disabled widows and widowers between the ages of 50 and 65.
3. Women age 50 or older entitled to mother's benefits who meet all requirements for SSA disability benefits.
4. Individuals age 18 and over who receive Social Security benefits because they became disabled before reaching age 22 (referred to as disabled adult children).
5. Disabled qualified Railroad Retirement beneficiaries.

C. In addition, the following may also receive Medicare

1. Individuals receiving hemodialysis for kidney failure;
2. Individuals receiving renal transplantation for chronic renal disease.

III. POLICY PRINCIPLES

A. Medicaid recipients who are 65 or older must enroll in Medicare Part B and Part D. If the recipient fails to enroll, Medicaid will not pay any portion of services that would have been paid by Medicare Part B and Part D. The provider may bill the recipient for those services. ~~If a person fails to enroll in Medicare Part B, charges which would have been paid by Medicare Part B cannot be applied to the deductible. (Refer to MA-2360, Medicaid Deductible.)~~

Refer to DHB Administrative Letter 09-23, Retroactive and Ongoing Dually Eligible Applicants/Beneficiaries – Medical Expenses.

B. For individuals who meet the eligibility requirements for Qualified Medicare Beneficiary – Q coverage, Medicaid pays for:

1. Medicare Part A & Part B premiums and
2. Medicare deductibles and co-insurance.

Refer to [MA-2130](#), Qualified Medicare Beneficiaries-Q.

NOTE: The individual may also be eligible for full Medicaid coverage as well as Qualified Medicare Beneficiary-Q coverage.

(III)

C. For individuals who meet the eligibility requirements for Qualified Medicare Beneficiary – B coverage, Medicaid pays for the Medicare Part B premium. (Refer to [MA-2140](#), Qualified Medicare Beneficiaries-B.)

NOTE: The individual may also be eligible for full Medicaid coverage as well as Qualified Medicare Beneficiary-B coverage.

D. For individuals who meet the eligibility requirements for Qualified Disabled Working Individuals, Medicaid pays for the Medicare Part A premium.

NOTE: The payment of the Part A premium for a Qualified Disabled Working individual is a manual process. These cases are not entered into EIS. The policy found in this section for enrolling them and paying the Part A premium do not apply. They are not mentioned again in this section. (Refer to [MA-2150](#), Medicaid-Working Disabled.)

E. For individuals who meet the eligibility requirements for Qualifying Individuals 1, Medicaid pays for the Medicare Part B premium. (Refer to [MA-2160](#), Qualifying Individuals 1.)

NOTE: Individuals eligible as Qualifying Individuals 1 are not eligible for full Medicaid coverage.

F. Always use the recipient's name, 1st, middle initial, and last and the same SSN that is shown on the Social Security records.

G. Buy-in does not process electronically for open-shut cases. The IMC must send a [DMA-5004](#), Buy-In Clerical Action.

IV. OVERVIEW OF MEDICARE COVERAGE

A. Coverage Under the Two Parts of Medicare, Part A and Part B

1. Part A Hospital Insurance

a. Most people who have Medicare hospital insurance do not pay monthly premiums for this protection since they have credits for work under Social Security. Those who do not have work credits must pay a monthly premium.

(1) Individuals who begin receiving Social Security retirement benefits at age 62 will be automatically enrolled for free Medicare Part A at age 65.

(2) Individuals who begin receiving Social Security benefits at age 65 are also enrolled in free Medicare Part A at the same time.

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(IV.A.1.a.)

- (3) Individuals who receive Social Security disability benefits are automatically enrolled in free Medicare Part A after 24 months.
- b. Individuals receiving SSI benefits based on disability (ineligible for Social Security disability) are not eligible for Medicare Part A. Once they reach age 65, they are eligible for Medicare Part A if they pay the premium.

Medicaid pays the Part A premium for Medicaid recipients who are not entitled to free Part A when they are authorized as MQB-Q or eligible for MAA, MAB, or MAD with Q class.

2. Part B, Supplementary Medical Insurance
 - a. Covers medically necessary physician's services, outpatient hospital services, outpatient therapy and speech pathology services. It also covers other medical services such as laboratory, X-rays and medical supplies, and home health services when the individual does not have Part A.
 - b. There is a monthly premium for Part B. The premium is deducted from the Social Security check, or billed quarterly to those persons who do not receive monthly Social Security benefits, but who qualify and are enrolled in Medicare Part B.
 - c. Medicaid pays the Part B premium for Medicaid recipients eligible for Part B coverage or Part C coverage.

B. Automated Notices

1. EIS generates letters to Medicaid recipients age 65 or older or within three months of turning 65 without an RSDI claim number. These people are eligible for Medicare Part B buy in. Medicaid classifications F, H, O, and R do not receive the notices. The notice continues to be sent to Medicaid recipients until the RSDI claim number is entered into the EIS. The notice is in English and Spanish.

The notice advises the recipient of the following information:

- a. To contact the Social Security Administration for an appointment to apply for Medicare Part B.
- b. Medicaid pays the monthly Medicare Part B premiums.
- c. Medicaid pays Medicare Part A and Part B sharing amounts (up to the Medicaid allowable rate) for doctor and hospital care.

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(IV.B)

- d. If the recipient fails to enroll in Medicare Part B, Medicaid does not pay for medical bills incurred that Medicare would have paid.
2. The return address on the automated recipient notice is the county dss address
3. NCXPTR displays two reports containing the name of each Medicaid recipient that receives the notice. The reports run monthly. Each report is sorted by county and then alphabetically by recipient name.
 - a. The report titles are DHRWDB AGE 65 NOTICE REGISTER and DHRWDB OVER 65 WITH NO RSDI #.
 - b. Caseworkers must review the reports to ensure those recipients received the notice. If the notice is returned, forward it to the correct address.
 - c. Caseworkers must review the DHRWDB OVER 65 report and verify monthly with SOLQ if the recipient is enrolled in Medicare. Once Medicare enrollment is verified, the IMC must enter Medicare A or B and the RSDI claim number into EIS.

C. Medicare Deductible/Coinsurance

1. Medicare beneficiaries are responsible for paying a federally determined deductible expense before Medicare will pay 80 percent of the Medicare allowable charge.
 - a. This expense is incurred at the beginning of a calendar year for Part B services and at the beginning of each new benefit period for Part A services. (See [MA-2360](#), Medicaid Deductible)
 - b. The Part A deductible may be incurred more than once per calendar year.
 - c. After the Medicare deductible has been met, beneficiaries are responsible for paying the coinsurance amount, which is the remaining 20 percent of the Medicare allowable charge.
2. Medicaid pays the Medicare cost sharing up to the Medicaid maximum allowable rate for expenses incurred by Medicaid recipients who receive Part A and/or Part B or Part C Medicare.

V. OVERVIEW OF MEDICARE BUY-IN

- A. Buy-in is the process by which the State Medicaid Program (Title XIX) notifies CMS that Medicaid has accepted responsibility for payment of Medicare premiums for a Medicaid recipient. CMS bills the state monthly for Medicare premium payments.**

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(V)

- B. Medicaid pays the Part B premium for all Medicaid recipients known to be enrolled in Part B.**
- C. Medicaid pays the Part A premium for Qualified Medicare Beneficiaries with "Q" class who are over age 65. See [MA-2130](#), Qualified Medicare Beneficiaries-Q, for regulations and procedures for MQB-Q.**

Part A buy-in is also available for recipients whose Medicaid classification is "Q" and whose RSDI claim number suffix is "M." The "M" suffix signifies that they are not entitled to premium-free Part A.

D. Federal Financial Participation (FFP)

1. FFP for the Medicare premium is available for recipients determined eligible as MAABD's, classified as "B", "C" or "Q", SAD's or SAA's classified as "C" or "Q" and MQBB's and MQBE's.
2. There is no FFP for recipients classified as medically needy "M" or categorically needy non-cash, "N." For these recipients, the state share is 85% and the county share is 15%.

- E. There is no federal participation in payment of medical costs for services that could have been paid by Medicare but the individual was not enrolled.**
- F. Buy-in is cost effective because Medicare pays the major portion of the charges and Medicaid only pays the Medicare cost sharing up to Medicaid's maximum allowable rate for the service.**

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VI. EFFECTIVE DATE OF BUY-IN COVERAGE

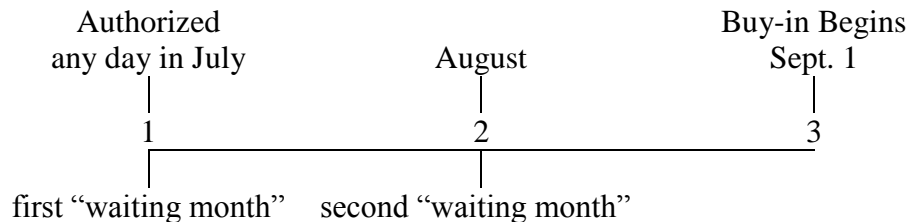
A. Part A Hospital Premium

If the individual is ineligible for free Part A, Medicaid pays the Part A premium for MQB recipients and other Medicaid recipients 65 or older with Q classification.

1. The effective date is always the date the person is authorized with a "Q" classification.
2. Recipients must be bought in for Part B before Part A buy-in can be accomplished.

B. Part B (Medical) Premium

1. Enrollment in Medicare must take place before buy-in can be accomplished.
2. Categorically Needy Cases (C, N, Q, E, or B classification)
 - a. The effective date of buy-in coverage is always the Medicaid effective date.
 - b. The only benefit for a/r's classified as MQBB or MQBE is payment of the Part B premium.
 - c. The IMC can process an initial approval with future Medicare Part B entitlement by approving an open/shut application for the months there is no Medicare coverage. Authorize an ongoing certification period for the remainder of the certification period with the month Medicare begins.
3. Medically Needy Cases (M classification)
 - a. There is a two-month waiting period for medically needy cases. The effective date of buy-in coverage is always the second month after the initial month of authorization for Medicaid.



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(VI. B.3)

- b. Once the client becomes eligible for Medicare Part B in an ongoing case and the classification is "M", the two-month waiting period applies before buy-in becomes effective.

Example:

Cert. Period	Authorized from	Medicare B Eff. Date	Buy-In Eff. Date
Jan. 2006 – Dec. 2006	Jan. 1, 2006	March 2006	May 2006

- (1) The "month of authorization" is the month of the first day of authorization in the retroactive or ongoing period.
- (2) If coverage is authorized in the retroactive period, those months count when the ongoing period is authorized.

EXAMPLE: Mrs. Jones is approved as a medically needy ("M") recipient for July and August in the retroactive period. Her ongoing application pends. If ongoing is denied, she is ineligible for buy-in. If any date in the ongoing c.p. or the next c.p. is approved, buy-in is effective September 1 and a manual accretion is required. See VII.D.

- c. If ongoing eligibility is approved as medically needy ("M") while the retroactive period is pending, the IMC must complete and mail a [DMA-5004, Buy-In Clerical Action](#), to the Medicaid claims processing contractor when the retroactive part is approved, indicating the correct effective date of buy-in.

EXAMPLE: Mr. Gray is approved for ongoing Medicaid effective September through February. His retro application pends. Buy-in begins November 1. His retro is later approved for June, July and August. A DMA-5004, Buy-In Clerical Action, must be completed to notify the Medicaid claims processing contractor to begin buy-in effective August.

- c. If the classification is "M" and the case is an open/shut application with only two months of authorization, buy-in is not applicable. Do not send a DMA-5004, Buy-In Clerical Action.
- d. In an "M" application, the IMC can process an initial approval with future Medicare Part B entitlement by approving an open/shut application for the months there is no Medicare coverage. Authorize an ongoing certification period for the remainder of the certification period with the month Medicare begins. The two month waiting period commences the month the applicant becomes eligible for Part B.

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(VI.)

C. Duration of Buy-In Coverage

1. Part A Buy-in

Buy-in for Part A stops when Medicaid is terminated or the Medicaid classification changes from "Q" to any other classification. However, SSA continues Part A coverage and bills the recipient for the Part A premiums.

2. Part B Buy-in

- a. Once buy-in is effective, it continues until the case is terminated or until the individual is deleted from the case.
- b. Once an initial Medicaid deductible is met, buy-in continues for the individual who is certified in deductible status after the initial authorization period ends. It continues throughout all subsequent certification periods until the case is terminated or until the individual is deleted from the case.
- c. Change in Medicaid classification does not stop buy-in coverage for Part B or change the effective date of buy-in.

VII. RECIPIENT ENROLLMENT IN BUY-IN

A. Electronic Accretions

Electronic accretion is a process by which a transaction is automatically sent to CMS in Baltimore to add a recipient to buy-in.

- 1. For newly approved cases when the a/r already has Medicare, the IMC must:
 - a. Verify accuracy through SOLQ and enter on the DSS-8124 or DSS-8125 the recipient name, first, middle initial and last, DOB, and RSDI that is shown in Social Security records. Medicaid uses the same name used by the Social Security Administration.
 - b. Enter the Medicare Claim Number including suffix exactly as it appears on the Medicare card or SOLQ.
- 2. For active cases in which the a/r becomes eligible for Medicare Part B, the IMC must:
 - a. Obtain the Medicare claim number including suffix or Railroad Retirement number from the Medicare card. Verify name, DOB, and RSDI on card or SOLQ.

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- b. Enter this number in the RSDI Claim Number block on the DSS-8125.
Note: Do not enter an SSI number.
 - c. Refer to the [Social Security Beneficiary Identification Codes](#) for a valid Medicare suffix or Railroad Retirement prefix.
3. Electronic accretions are not processed for open/shut cases. Complete a [DMA-5004](#), Buy-In Clerical Action, for open/shut cases with buy-in eligibility. See Section VI. B. 3. c. for instructions.

Electronic accretions are not processed for cases authorized for retroactive coverage, when the ongoing period pends due to a deductible. Complete a DMA-5004, Buy-In Clerical Action, for cases when buy-in is applicable.

B. Actions Taken By State/Medicaid or Claims Processing Contractor to Initiate Buy-In

1. An electronic file is created monthly for all recipients who do not have buy-in but have RSDI claim numbers on EIS indicating potential eligibility for Medicare Part B.
 - a. This file is prepared by the Medicaid claims processing contractor and submitted to CMS in Baltimore by the 25th of each month.
 - b. The file contains the same information that is on the State Eligibility Information System (EIS) file.
 - c. Information submitted to CMS in Baltimore is checked against the Health Insurance Master Record.
2. The transactions sent to CMS are shown on a monthly printout called the List of Actions sent to Baltimore. A copy of the List of Actions is mailed to the county each month for information and reference. Refer to Part A and Part B Buy-In Transaction Codes, to see transactions.
3. CMS processes the transactions and returns the responses to the State in the next buy-in cycle. State buy-in files are updated upon receipt of acknowledgement from CMS that the transactions have been successful. This exchange of information can take up to 90 days. The county may verify from the SOLQ to determine if buy-in is accomplished.

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C. Accretions By SSA

SSA automatically enrolls any Medicaid recipient in buy-in who identifies himself as Medicaid when making application for Medicare Part B.

The SSA district office must contact the county dss to verify:

1. Medicaid authorization date;
2. Medicaid aid program/category;
3. Medicaid classification;
4. County of residence;
5. Individual ID number.

D. Manual Accretions

1. The [DMA-5004](#), Buy-In Clerical Action, is designed to report those cases in which the electronic process has failed to enroll the person in buy-in.
 - a. Send a DMA-5004, Buy-In Clerical Action, 90 days or sooner for Part D, after the Medicaid application has been approved and the recipient is not on buy-in after verification on the SOLQ.
 - b. Send a DMA-5004, Buy-In Clerical Action, for SSI recipients authorized for Medicaid by the county for a retroactive period at the time of approval. Buy-in for retroactive authorization will not be processed electronically for SSI recipients.
 - c. Send a DMA-5004, Buy-In Clerical Action, for situations as referenced previously in sections VI. B. 3. c. and d. Follow instructions for completion that are found on the reverse side of the form.
2. Actions to be taken by the IMC
 - a. Verify the Medicare claim number, name, DOB and entitlement date from:
 - (1) Most current Bendex or SOLQ.
 - (2) State Online Query (SOLQ). Page 3 of the SOLQ response contains valid effective dates for the recipient's Health Insurance (HI; Medicare Part A) and Supplemental Medical Insurance (SMI; Medicare Part B). Refer to the EIS Manual, [EIS 1107, State Online Query/Third Party Query](#), VII. B. 2., for an explanation of the information on the screen for Part A and/or Part B effective dates.

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(VII. D. 2.)

- b. Compare the following information on EIS to the SOLQ, Bendex and/or Medicare card for an exact match. Refer to the EIS Manual, [EIS 1107, State Online Query/Third Party Query](#).
 - (1) Medicare claim number (Title II Claim Account Number on SOLQ);
 - (2) Medicare claim number suffix;
 - (3) Name, 1st, middle initial and last.
- c. Buy-in does not process without an exact match on the claim number, suffix, and name. Never use the claim number and suffix that appears on the SSI check.
- d. If the information is an exact match, and a buy-in accretion action does not appear on the "List of Actions," complete the [DMA-5004, Buy-In Clerical Action](#). Attach the SOLQ response and send to the Medicaid claims processing contractor.
- e. If the information does not match:
 - (1) Change the information in EIS to agree with the information on the SOLQ response;
 - (2) Complete the DMA-5004, Buy-In Clerical Action. Attach the SOLQ response and send to the Medicaid claims processing contractor.
- f. Do not send a DMA-5004, Buy-In Clerical Action, to Medicaid until the recipient has applied, been enrolled and is a recipient of Medicare.
- g. The IMC must send a DMA-5004, Buy-In Clerical Action, when a new applicant is authorized for CAP services; otherwise, buy-in does not process.

E. Electronic Deletions from Buy-In

1. Electronic deletion is a process to terminate a recipient from buy-in when the case is terminated or a recipient is deleted from Medicaid.
2. Deletions are handled by the same method and on the same 90-day time schedule as accretions.

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(VII.E.2.)

- a. Termination or deletion of the recipient from Medicaid will cause deletion from buy-in.
 - b. The effective date for buy-in termination is the date of the Medicaid termination.
 - c. Recipients are not successfully deleted from buy-in if the recipient's name or Medicare claim number on State Medicaid files does not match that on CMS files. Deletion attempts will be rejected by CMS until the information matches, even though the Medicaid case may have been closed or the recipient deleted from the Medicaid case. This results in incorrect payment of Medicare premiums.
3. Deletions due to death of the recipient are processed using the month of death, regardless of the date Medicaid is terminated.
 4. SSA deletions may be for any number of reasons, including death of the recipient, move to another state, or ineligibility due to cessation of disability. These deletions indicate the effective date of termination from buy-in.

The IMC must check the SOLQ each month to determine if SSA took appropriate action.

5. If a recipient has been deleted in error, a copy of the notification letter from SSA advising the recipient of the deletion should be attached to the [DMA-5004](#), Buy-In Clerical Action, and submitted to Medicaid for manual re-accretion.

If the recipient did not receive a letter from SSA, research and document the reason for non receipt, and attach to the DMA-5004, Buy-In Clerical Action, and submit to Medicaid for manual re-accretion. Notify SSA of recipient non receipt of the letter.

F. Effects of Accretion and Deletion on the SSA or RR Check

1. Because it may take up to 90 days for accretion to take place, two to three premiums are deducted from the recipient's check after the effective date of buy-in.
 - a. Premiums paid by the recipient after the buy-in effective date are refunded to the recipient by Social Security or Railroad Retirement.
 - b. When the recipient is on buy-in and premiums continue to be deducted from the Social Security check, the IMC must verify the premium deduction and indicator on SOLQ, or contact the Buy-In Coordinator in the Claims Analysis Unit at DMA to confirm Medicaid buy-in accretion has taken place.

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(VII. F.1. b)

Once accretion has been verified, the IMC must call the representative at the local Social Security office or e-mail their office at www.ssa.gov/ for corrective action. The recipient's name, HIC number, and Social Security number are needed for this request. The Social Security representative completes and submits a Manual Development Worksheet (MDW) to the Medicare Payment Center to correct Payment Center records.

Do not contact the SSA office unless the recipient is listed on the SOLQ with a premium amount or the Buy-In Unit has verified accretion.

- c. Please allow 90 days after Medicaid approval before inquiring with Social Security Administration about refunds.
2. Because it takes 90 days for buy-in to terminate after the case is terminated (or the individual is deleted from the case), Medicaid pays two or three premiums after termination of benefits.
 - a. Premiums paid by Medicaid after termination/deletion, are credited to the State.
 - b. Premium amounts are deducted in a lump sum from the individual's next SSA/RR check.

VIII. COUNTY RESPONSIBILITY TO ASSIST WITH MEDICARE APPLICATION

A. Application for Medicare Enrollment

Except for individuals entitled to free Part A, who are automatically enrolled for Medicare Part A by Social Security, the a/r must apply for Medicare benefits. Social Security makes the determination for Medicare coverage. Upon application for Medicaid, the a/r must accept all available Medicare benefits.

1. Application for Medicare may be made anytime during the year for a Medicaid a/r if Social Security is informed of his Medicaid status. Other individuals are restricted to an open enrollment period of January, February and March if they refuse coverage at the initial enrollment period.
2. Application for Medicare is made at the local Social Security office. If eligible, the a/r receives a Medicare card, which indicates his eligibility for Part A and/or Part B. He must present the Medicare card and the Medicaid card to providers of medical services for proof of coverage and billing to the appropriate parties.

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3. If a Medicaid a/r is eligible for Part B benefits, he must apply for and accept this coverage. If he refuses, the a/r is responsible for payment of claims that would have been paid by Medicare Part B if the a/r had applied. If the a/r fails to enroll in Medicare Part B, charges which would have been paid by Medicare Part B cannot be applied to the deductible.
4. If the a/r has free Part A but has previously refused Part B, he does not need to make an application for Part B. When Medicaid submits the buy-in transaction to CMS, SSA automatically enrolls him in Part B and sends him a corrected Medicare card.
5. If the a/r has Part B only, an application for premium Part A Medicare is not required. Medicaid pays Part A premiums for "Q" class recipients whose RSDI claim number suffix is "M." He is eligible for MQBB regardless of whether or not Medicaid is paying the premium for Part A or he is paying for the Part A premium out of pocket.

B. Failure to Apply for Medicare

1. Medicaid a/r's who are age 65 or older must apply for and be enrolled in Medicare Part B. If the a/r fails to enroll, Medicaid pays no portion of the costs for medical services that would have been covered by Medicare Part B. The provider may bill the recipient for the total cost of services provided.
2. At the following times, inform individuals who are potentially eligible for Medicare Part B that they must apply for Medicare Part B coverage:
 - a. At application for Medicaid, and
 - b. When the "age 65" message appears on the Case Management Report.
3. If an a/r, age 65 or older, is authorized for retroactive Medicaid, claims for medical services covered by Medicare Part B are processed based on the information below.
 - a. If categorically needy, and the recipient is enrolled in Part B, enter the RSDI claim number in EIS. If the recipient has paid his Part B premiums for the retroactive period, Medicaid pays the Part B premiums for the retroactive months and SSA reimburses the recipient. This requires a manual accretion using a DMA-5004, Buy-In Clerical Action, for the retroactive period.
 - b. If categorically needy, and the recipient is not enrolled in Part B, claims are pended for buy-in to occur. If buy-in does not occur, claims are denied with instructions to bill the recipient. If buy-in does occur, claims are denied with instructions to file with Medicare. The recipient must enroll in Part B to have coverage for the retroactive and ongoing months.

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(VIII. B. 3)

- c. If medically needy, and the recipient is enrolled in Medicare but has not paid his Part B premiums for the two waiting months, claims bypass the Medicare suspect edit for the two month waiting period and pay. Enter the RSDI claim number in EIS; Medicaid pays the Part B premiums for the months after the waiting period has been served.
- d. If medically needy, and the recipient is not enrolled in Part B, claims bypass the Medicare suspect edit for the two month waiting period and pay. Claims for services after the waiting months are denied with instructions to bill the recipient. After buy-in has occurred, the provider is instructed to bill Medicare first.

C. Apply for Medicare B for A/R Who Is Unable To Apply

1. If an a/r fails to apply for Medicare Part B, the IMC must explain the reasons for application and that the State pays the premiums as long as he is a Medicaid recipient, including those months he is on a deductible. Explain to the a/r that he is responsible for payment of claims that would have been paid by Medicare if the a/r had enrolled.
2. The IMC must assist representatives of deceased a/r's or a/r's who are physically or mentally unable to make an application for themselves and no responsible family member can be located who will apply for Medicare Part B for them.
3. The IMC should call SSA to make an appointment for Medicare Part B application for a/r's who are unable to apply for Medicare Part B coverage. The IMC must provide SSA with any information necessary to process the Medicare application. If the SSA office refuses to work with the IMC, contact the Medicaid Eligibility Unit.

D. Obtain Proof of Age

1. Ask the a/r to provide a birth certificate.
2. If the a/r has no birth certificate, the IMC must obtain the birth certificate through the local Register of Deeds or State Vital Records Office, and pay a fee.
3. If the IMC cannot obtain a valid birth certificate for the a/r, other items can be used in lieu of a birth certificate such as military records, school records, marriage license, census records, etc. Refer to the [DHHS/SSA Listing of Proofs](#), for additional proofs.

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4. If no proof acceptable to SSA can be obtained to verify the a/r's date of birth, the IMC must apply for search of census records. Refer to [Application for Search of Census Records](#), for a copy of the application.
 - a. Complete the application and mail to:

Bureau of the Census
1600 N. Walnut Street
Pittsburg, Kansas 66762
 - b. There is a substantial fee for an application to be processed by the Census Bureau.

E. Apply for Medicare Part B For a Deceased Individual

1. If the deceased a/r was 65 years of age and did not have Medicare Part B, only the county DSS can make a Medicare Part B application for him.
 - a. Determine that the deceased a/r is eligible for Medicare Part B coverage. For Medicare coverage groups refer to Section III.
 - b. Contact SSA and make application for him. See IV. C. above.
 - c. If SSA tells the IMC that he cannot apply for a deceased a/r, refer SSA to POMS HI 00815.051.
2. Once Medicare Part B is established, the IMC must complete a [DMA-5004](#), Buy-In Clerical Action, to accrete the a/r for buy-in. The automatic accretion process does not take place for a deceased a/r.

IX. CHARGEBACKS FOR COUNTY ERRORS

Medicaid recipients age 65 and older must be enrolled in Medicare. The county may be charged if an erroneous claim number has been entered in EIS and buy-in cannot be terminated. Refer to [MA-2395](#), Corrective Actions and Responsibility for Error. The following actions transpire when county errors occur.

- A. Counties are notified of the recipient's erroneous Medicare claim number by letter with an attachment (2161 reject from Baltimore) indicating the invalid Medicare number.**
- B. Counties must respond within 90 days with proof of correct Medicare number for the recipient.**
- C. Counties are notified by DMA-5017, County Chargeback Notice, of the total amount for erroneous Medicare premium payments.**

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X. PROCEDURES FOR ALIENS

A. Residency Requirement

Aliens must have lived in the United States for at least five consecutive years and be age 65 or older to be eligible for Medicare.

B. Case Management Report, Special Message, "Age 65 In MMM."

Review the case management report produced by EIS and sent to the county dss monthly. An aged alien who is authorized for Medicaid and does not have a valid RSDI claim number in EIS appears on this report.

1. Aged Aliens Who Do Not Have Five Years of Residence
 - a. If the alien appears on the case management report, enter the individual's Social Security number with a "Z" suffix in the RSDI claim number block on the DSS-8125 under individual data. This allows claims for the alien to bypass Medicare suspect editing. These individuals are not qualified to enroll in Medicare Part B and procedures in Section IV. do not apply.
 - b. Check the aged alien's passport for the latest entry date into the United States. (A/R must have five years of continuous residency before he qualifies for Medicare Part B.)
2. Aged Aliens Who Have Five Years of Permanent Residence
 - a. An application for Medicare must be made by the a/r, his representative, or the IMC following procedures in Section VIII.
 - b. When Medicare is approved, enter the valid RSDI claim number for buy-in accretion.

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XI. INFORMATIONAL MATERIALS SENT TO COUNTIES

A. Code 23 Report

This report from CMS informs the State that the recipient's claim number and/or claim number suffix has been changed. CMS sends a code 23 for an ongoing buy-in transaction or as a response to a State-initiated accretion, deletion or change attempt. The Code 23 Report includes the recipient's name, MID, new HIC (Medicare claim number), old HIC, SSI indicator, sex, DOB, and transaction code and effective date.

Verify through SOLQ and social security records that the claim number on the case profile, individual data, and RSDI number, and in EIS match the new HIC number on the Code 23 Report (IX.). If not, make appropriate changes to correspond with the social security records information.

B. List of Actions Sent to Baltimore

The List of Actions Sent to Baltimore is a printout of all transactions sent on the monthly buy-in file to CMS in Baltimore.

1. It includes all new accretion and deletion requests as well as requests to change the Medicaid ID number (code 99).
2. Individuals are listed in alphabetical order.
3. Transactions on this report, which are accepted by CMS, should appear on the following month's SOLQ.
4. The List of Actions is forwarded to the counties monthly for information. The IMC must check the list of actions to determine if proper information was sent before requesting clerical action on the DMA-5004, Buy-in Clerical Action. Refer to Part A and Part B Buy-In Transaction Codes, to see transactions.

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(XI.)

C. Medicaid Recipients Reaching Age 65 Who Should Be Enrolled In Medicare Part B

This printout is an accumulative listing of recipients who are reaching 65 years of age and have not enrolled in Medicare Part B or do not have an RSDI claim number entered in the Eligibility Information System (EIS) file.

1. Verify the Medicare claim number (including the suffix) for recipients reaching age 65 from the Medicare card, Bendex, or SOLQ.
2. Enter the Medicare claim number in the RSDI claim number field on the DSS-8125 screen.
3. If the recipient has not enrolled in Medicare, assist him in making the application for Medicare. See VIII. above.
 - a. The a/r may apply for Medicare coverage once he reaches 64 and nine months of age.
 - b. Ask the a/r to provide a copy of his birth certificate for proof of age.
 - c. If the a/r does not have a birth certificate, assist him in obtaining proof of age. See VIII. D. above.