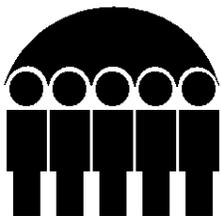


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Employees' Manual
Title 6
Chapter E

EXTRA HELP FOR MEDICARE PRESCRIPTION DRUG COSTS



Iowa
Department
of
Human Services

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Introduction

| This chapter contains instructions for handling inquiries and applications for the Medicare “extra help with the Medicare prescription drug costs” benefit.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), established the Medicare Prescription Drug Program, also known as Medicare Part D. | The new program went into effect January 1, 2006.

Medicare beneficiaries who wish to enroll in the Medicare Prescription Drug Program | must choose a prescription drug plan through which to receive the benefit. Each year there is an initial open enrollment period from November 15, through December 31st, during which beneficiaries can enroll in a plan.

Generally, coverage for the drug benefit will be provided by private prescription drug plans that offer drug-only coverage, or through Medicare health plans that offer both prescription drug and health care coverage. Both types of plans must offer a standard drug benefit, but will have the flexibility to vary the drug benefit.

Covered Part D drugs are essentially the same drugs and biologicals that are approved for the Medicaid program (although selection may be restricted through a plan’s formulary) and they must be dispensed by prescription and on an outpatient basis. Drugs and biological products that are paid for by Medicare Part A or B are excluded.

The MMA also provides extra help (a subsidy) with prescription drug costs for eligible individuals whose income and resources are limited. This help takes the form of subsidies paid by the Federal government to the drug plan in which the Medicare beneficiary enrolls.

| The subsidy provides assistance with the premium, deductible and copayments of the program. Beneficiaries may apply for the Low-Income Subsidy (LIS) with the Social Security Administration (SSA) or with the Department of Human Services.

For beneficiaries who apply for the subsidy, the type of income to be counted will be based on the rules of the Supplemental Security Income (SSI) program. Generally the income of the applicant and that of the applicant’s spouse who resides with the applicant will be counted.

Once counted, income will be compared to the federal poverty level standard applicable to the size of the applicant's family to determine eligibility. Family size includes the applicant, the spouse residing with the applicant, and the number of people who are related to the applicant or spouse, are living in the applicant's household, and depend on the applicant or spouse for at least one half of their financial support.

Resources (assets) are considered in determining eligibility for a subsidy. Resources that will be considered in determining eligibility generally include liquid resources that can be readily converted to cash within 20 days (e.g., checking and savings accounts). Also countable is real property that is not the applicant's primary residence and not attached to the primary residence.

The resources of the applicant and spouse, if any, will be counted to determine if the applicant meets the resource threshold to be eligible for a Part D Low-Income subsidy. Resources of dependent family members are not counted for the applicant and their spouse. If dependent family members are Medicare beneficiaries themselves, they must file their own subsidy application or be deemed eligible in their own right.

The new law requires both Social Security and the states to accept and process applications for the low-income subsidy (LIS). The law also requires states to screen subsidy applicants who apply at the state Medicaid office for eligibility for the Medicare Saving Programs (qualified Medicare beneficiary [QMB], Specified low-income Medicare beneficiary [SLMB], and qualified individual [QI]).

Acronyms

BWE: blind work expenses.

CMS: the Centers for Medicare and Medicaid Services, formerly known as the Health Care Financing Administration (HFCA).

IRWE: impairment-related work expenses.

LIS: low-income subsidy.

MSP: Medicare Saving Programs (QMB, SLMB, and QI).

SSA: the Social Security Administration.

SSI: Supplemental Security Income.

Questions and Answers About Medicare Part D

Q. Who qualifies for Medicare Prescription Drug Coverage?

A. A person is eligible for Medicare Prescription Drug Coverage if the person:

- ◆ Is entitled to Medicare Part A or enrolled in Medicare Part B, and
- ◆ Lives in the service area of a prescription drug plan or Medicare Health Plan with Prescription Drug Coverage. (“Service area” does not include facilities in which people are incarcerated but otherwise covers the 50 states, District of Columbia and U.S. Territories.)

Q. How is Medicare prescription drug coverage funded?

A. Medicare Prescription Drug Coverage is a Medicare benefit and, unlike Medicaid, is funded entirely with federal dollars. There are no state funds involved.

Q. What is the standard coverage (without extra help)?

A. Medicare beneficiaries will have access to the standard drug coverage described below. Although drug plan sponsors may change some of the specifications below, the coverage offered must at least be equal in value to the standard coverage. Standard coverage includes:

- ◆ A monthly premium of about \$29.50.
- ◆ A yearly deductible of \$265.
- ◆ Copayment of 25 percent up to an initial coverage limit of \$2,400.
- ◆ Protection against high out-of-pocket prescription drug costs, with copayments of generally \$2.15 for generics and preferred drugs and \$5.35 for all other drugs, or 5 percent of the price, once the enrollee’s yearly out-of-pocket spending reaches \$3,850.

Q. What is the extra help with drug plan costs?

A. The extra help is financial assistance with the monthly premium, the yearly deductible, the per-prescription copayment, and continuous coverage with no gap before reaching \$3,850 in out-of-pocket spending. The help may be full or partial depending on the income, family size and resources of the beneficiary.

Q. What is the full extra help?

A. Beneficiaries with very low savings and incomes will receive:

- ◆ A \$0 yearly deductible.
- ◆ A \$0 monthly premium if their drug plan’s premium does not exceed the LIS premium subsidy amount.
- ◆ Continuous coverage before catastrophic coverage.
- ◆ Copayments of not more than \$2.15 for generics and preferred drugs and not more than \$5.35 for other drugs up to the out-of-pocket limit.
- ◆ No copayments for prescriptions after reaching \$3,850 in out-of-pocket spending.

Beneficiaries with Medicare and Medicaid and income at or below 100% of the FPL will have copayments reduced to \$1 and \$3.10, respectively, up to the out-of-pocket limit. Beneficiaries who have full Medicaid benefits and reside in an institution will have no copayments.

Q. What is the partial extra help?

A. Beneficiaries with limited savings and income below 150% of the federal poverty level can enroll in a plan with:

- ◆ A sliding scale monthly premium that is between \$0 and about \$29.50.
- ◆ A \$53 yearly deductible.
- ◆ Continuous coverage before reaching \$3,850 in out-of-pocket spending.
- ◆ Coinsurance of 15% up to the out-of-pocket limit (\$3,850).
- ◆ Copayments of \$2.15 and \$5.35, respectively, beyond the out-of-pocket limit.

Q. What will standard Medicare prescription drug coverage look like for someone who qualifies for extra help?

A. People with Medicare and income below 135% of the federal poverty level and resources of \$7,620 for an individual or \$12,190 for a couple will pay no premium¹ or deductible and nominal copayments of up to \$2.15 for generics and preferred multiple source drugs and \$5.35 for other drugs.

Once their copayments plus the amount Medicare pays as the extra help reach \$3,850, they will pay nothing for their prescriptions. For people with Medicare, full Medicaid benefits, and income less than 100% of poverty, they will have copayments of up to \$1 for generics and preferred multiple source drugs and up to \$3.10 for other drugs.

Again, once their copayments plus the amount Medicare pays as the extra help reach \$3,850, they will pay nothing for their prescriptions. People with Medicare and full Medicaid benefits and who reside in an institution pay no premiums, no deductibles, no coinsurance, and no copayments.

People with Medicare and income below 150% of the Federal poverty level and resources up to \$11,710 for an individual or \$23,410 for a couple will only pay a \$53 deductible, cost-sharing up to \$3,850.

Q. How will Medicare Prescription Drug Coverage work for Medicare beneficiaries who are children?

A. Beneficiaries eligible for Medicare and Medicaid who are under 21 years of age have prescription drug benefits guaranteed under the Early & Periodic Screening, Diagnosis & Treatment Program. To the extent that the child's prescription drugs are not covered by the Medicare prescription drug plan, the state Medicaid program must provide drug coverage. Federal financial participation is available for this activity.

¹ The beneficiary's premium is subsidized up to the low-income premium subsidy amount as defined in 42 CFR §423.780(b).

Q. What is the difference in the extra help available to people who have Medicare and full Medicaid and beneficiaries who are eligible for MSP?

A. The benefits are the same except for copayments: people with income below 100% of the federal poverty level have lower copayments than those whose income is between 100% and 135% of the federal poverty level.

Q. Will the extra help “work” if the beneficiary does not choose a prescription drug plan?

A. No. Enrollment in a prescription drug plan may occur before or after application for the extra help, but it is important to remember that the extra help provides no benefit if the beneficiary is not enrolled in a prescription drug plan. Most Medicare beneficiaries must actively enroll in a prescription drug plan. The exceptions are:

- ◆ Beneficiaries who are already enrolled in a Medicare health plan with prescription drug coverage.
- ◆ Persons who automatically qualify for extra help (persons eligible for SSI-cash only, QMB, SLMB, and QI, but not full Medicaid) will get enrollment into a prescription drug plan facilitated if they do not choose a plan. Beneficiaries who qualify automatically for extra help may change plans if they do not wish to remain in the plan chosen for them.
- ◆ Beneficiaries who apply for the extra help on their own and who are found eligible but who do not enroll in a prescription drug plan will be enrolled into a plan. These beneficiaries will have an opportunity to change plans if they wish.

Q. If someone gets extra help, will Medicare enroll the person in a prescription drug plan?

A. Encourage everyone with Medicare to look at information about the Medicare prescription drug plans in their area and enroll in one that meets their needs. However,

- ◆ If a person with Medicare and full Medicaid benefits doesn't enroll in a Medicare prescription drug plan, then Medicare will enroll the person in a plan automatically to ensure continuous drug coverage.
- ◆ If a person with Medicare also gets Supplemental Security Income (but no Medicaid) or gets help paying Medicare premiums, deductibles or co-insurance from the Department (Medicare Savings Programs) but doesn't enroll in a Medicare prescription drug plan, then Medicare will enroll the person in a plan unless the person asks not to be enrolled.
- ◆ If someone is found eligible for this extra help but doesn't enroll doesn't enroll in a Medicare prescription drug plan, then Medicare will enroll the person in a plan unless the person asks not to be enrolled.

If a person who has been automatically enrolled finds that there is a different Medicare prescription drug plan that better meets the person's needs, the person can change to this plan at any time.

Q. What if people do not join a Medicare prescription drug plan? Can they still get extra help with their prescription drug costs?

A. People must enroll in a Medicare prescription drug plan in order for the extra help to apply to their prescription drug costs, such as premiums and cost sharing.

Q. How do people know if they qualify for the extra help?

A. Anyone who may qualify for the extra help is encouraged to apply, and can do so by calling the Social Security Administration at 1-800-772-1213, by visiting www.socialsecurity.gov on the web or a local DHS office.

Q. Are applications for the extra help available online?

A. Yes. Applications are available on the SSA web site at www.socialsecurity.gov. The application can be filed from this web site.

Q. Should a person who has prescription drug coverage from an employer or union plan apply for the extra help?

A. People with limited income and resources may qualify for extra help even if they have employer or union coverage. These people should talk with their plan or benefits administrator to find out how their coverage will work under Medicare prescription drug coverage.

A person who qualifies for extra help should also contact the Health Insurance Assistance Program (SHIP) at 1-800-351-4664. A SHIP counselor can provide personalized assistance to help the person decide whether it is better to keep the employer or union drug coverage or get Medicare prescription drug coverage.

Q. When should a person who is pending spenddown for Medicaid apply for the extra help?

A. A beneficiary who is already an MSP recipient will automatically be qualified for the extra help. A beneficiary who is not an MSP recipient must apply for the extra help and may do so at any time. There is no need for beneficiaries to apply for the extra help when they meet Medically Needy spenddown requirements because they will automatically qualify for the extra help based on receipt of Medicaid.

Q. How and where does someone apply for the extra help?

A. An application for extra help may be filed with either SSA or a local Department of Human Services office. Department local offices may assist people completing the SSA application by sending the completed applications to SSA for processing.

If a person requests a state application and a Department eligibility determination, then the person must follow the Department's eligibility process, including the Department's process for appeals and redeterminations.

Q. Does it make a difference if a person goes to the Social Security Administration or the Department to apply for the extra help?

A. No. The rules for determining eligibility are based on national standards that both SSA and the Department will use. We strongly encourage people to use SSA's simplified application that relies on automated data matches for verification of income and certain liquid resources, minimizing both paperwork burden and cost.

Q. Do people need to apply for the extra help in person?

A. No. People do not need go to SSA field offices or local DHS offices to apply. They may apply by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778) or they may mail their completed applications to the Social Security Administration Wilkes-Barre Data Operations Center or complete an online application at www.socialsecurity.gov.

Q. Who can help someone apply for the extra help?

A. Other people can fill out the application for someone to see if the person qualifies for the extra help. They are called personal representatives and can be any of the following:

- ◆ The person who acts on someone's behalf if that person is incapacitated or can't make decisions.
- ◆ Anyone the applicant chooses to act as the representative, such as a spouse, child or caregiver.
- ◆ The representative payee whom the Social Security Administration selects to act on someone's behalf or a person authorized under state law to represent someone.

Q. How will the Department and the Social Security Administration know if someone automatically qualifies for extra help and does not need to apply?

A. CMS will notify the person with Medicare and the SSA and the Department of the person's automatic eligibility for extra help.

Q. How will the Department or the Social Security Administration know if someone with Medicare is already eligible for extra help?

A. CMS works with SSA and the Department to facilitate information sharing, so that CMS will know whether a person is found eligible by SSA or the Department.

Q. Is the Department required to take applications for the extra help from residents of other states?

A. No. However, you should assist people with Medicare in filling out and filing the SSA application for extra help. If someone who does not reside in Iowa asks for a DHS eligibility determination, direct them to apply in their state of residence.

Q. How will DHS or SSA decide if a person qualifies for the extra help?

A. The type of income to be counted is similar, but not identical to the rules of the Supplemental Security Income program.

Generally the income of the applicant and that of any spouse who resides with the applicant will be counted. Income will be compared to a federal poverty level standard for the size of the applicant's family. Family size includes the applicant, the spouse residing with the applicant, if any, and the number of people who are related to the applicant, living in the same household, and dependent on the applicant or spouse for at least one-half of their financial support.

Resources that will be counted generally include liquid resources that can be readily converted to cash within 20 days (e.g., checking and savings accounts) and real estate that is not the applicant's primary residence. The resources of the applicant and the spouse, if living with the applicant, will be counted to determine if the applicant meets the resource threshold to be eligible.

Q. What counts as income and resources?

A. The extra help has special income rules, based on but not identical to the rules for the Supplemental Security Income (SSI) program. The rules for counting resources are, for the most part, the same as the standard SSI resource rules. The main difference is that most non-liquid resources will not be counted when determining eligibility for the extra help, whereas many non-liquid resources are counted for SSI.

The income of the applicant and that of a spouse living in the same household will be counted and compared to a federal poverty level standard for the size of the family, which includes the applicant, spouse, and dependent family members who live with them.

The resources of the applicant and the spouse will be counted and compared to the resource threshold. These generally include liquid resources that can be readily converted to cash within 20 days, such as checking and savings accounts, and real estate that is not the applicant's primary residence.

Q. Do applicants have to sell their cars, farms or ranches to qualify for the extra help?

A. No. Vehicles and any farm or ranch land that is adjacent to the primary residence are not counted as resources.

Q. Do applicants have to cash in their life insurance policies to qualify for the extra help?

A. No. However, if the policies have a total face value (i.e., death benefit) of \$1,500 or more, the cash value of the policies counts towards the resource limit.

Q. What effect does a Medicaid penalty have on eligibility for the extra help?

A. Eligibility for the extra help is not affected by a Medicaid penalty for disposal of an asset for less than fair market value.

Q. Can a person who applies for extra help with the Department and is found ineligible then apply for the extra help with SSA or vice versa?

A. People may file with either SSA or the Department, or both. However, SSA and Department use the same set of national rules. Rather than filing a new application, a person who believes the decision was incorrect is encouraged to file an appeal.

Q. How will prescription drug plans know if their members qualify for extra help?

A. CMS will inform plans offering Medicare prescription drug coverage which of their enrollees are eligible for the extra help, and the amount of assistance for which they qualify.

Q. Does a person who is determined eligible for extra help also qualify for other federal assistance?

A. No, not automatically. As part of making an eligibility determination, DHS is required to screen applicants for Medicaid and the Medicare Savings Programs and offer enrollment if the person meets the Medicare Savings Programs requirements. CMS will identify people who apply at SSA and who may also qualify for Medicare Savings Programs under the state's Medicaid program.

Q. Will a person lose extra help if, during the year, the person loses status as automatically qualifying for the extra help?

A. The beneficiary will not lose the help during the calendar year. The change would be effective January 1.

Q. If a person is found ineligible for extra help but later in the year loses a spouse or income or resources go down, can the person reapply?

A. Yes. However, remember that people must be enrolled in a Medicare prescription drug plan to get extra help.

Q. Does a person who moves out of state have to reapply for the extra help?

A. A person will remain eligible for the remainder of the year that began with the month of application for extra help. A person who filed with SSA must tell SSA the new address, but does not need to reapply. A person filed with the Department needs to file with the new state or with SSA before the end of the year in order for coverage to continue into the next year.

Q. If a person applies for extra help and is found eligible for premium assistance, a reduced deductible and cost-sharing, but later in the year becomes eligible for full Medicaid benefits, will the person then automatically get the premium assistance, \$0 deductible and \$0-\$5.35 copayments?

A. Yes. The Department will transmit this information to Medicare for the beneficiary to receive the assistance for which the person qualifies. CMS will notify the person that the person is automatically eligible for the premium assistance, \$0 deductible and \$0-\$5.35 copayments.

Q. If someone enrolls in a Medicare prescription drug plan and later qualifies for the extra help, does the plan have to repay the person for any cost-sharing incurred?

A. Yes. The plan will reimburse the enrollee back to the effective date of the extra help, which is the first of the month in which the application is filed. If a person is determined to be eligible for extra help retroactively, the plan will also have to reimburse the enrollee back to the start date of their eligibility.

Q. How often does a person need to be redetermined eligible for the extra help?

A. SSA and the Department will set their respective redetermination timeframes, with the Department basing its timeframes on its Medicaid rules. If a person automatically qualifies for extra help because of having full Medicaid benefits, gets help paying Medicare premiums from the Department, or gets Supplemental Security Income (SSI), then the person's eligibility remains in effect for calendar year.

In August of each year, CMS will verify that a person still automatically qualifies for extra help for the next calendar year.

Applying for the Subsidy

Beneficiaries with limited income and resources who do not fall into one of the deemed subsidy groups **must apply** for the low-income subsidy.

Deemed Subsidy Groups

Certain groups of Medicare beneficiaries automatically qualify for the low-income subsidy and do not have to apply. These groups are deemed eligible for the subsidy for a calendar year. The following groups are deemed eligible:

- ◆ Full-benefit dual eligibles who are persons eligible for both Medicare and full Medicaid benefits.
- ◆ Supplemental Security Income (SSI) recipients, including SSI recipients who receive a cash benefit but not Medicaid.
- ◆ Medicare beneficiaries who are participants in the Medicare Saving Programs, which are QMB, SLMB, and QI.

Deemed eligibles do not need to file an application for the subsidy. The Centers for Medicare and Medicaid Services (CMS) will automatically award them the subsidy, based on information received from the states and the Social Security Administration, and notify them that they are eligible without having to file an application. They do, however, need to choose a prescription drug plan. Deemed eligibles who fail to choose a plan will be enrolled by CMS in a plan.

People who reach age 65 or reach their 25th month of receipt of disability benefits and become eligible for Medicare after January 1, 2006, will be processed monthly. CMS will determine if they can be deemed eligible for the subsidy and notify them if they need not apply. If deeming is not applicable, these people may apply for the subsidy.

How to Apply

Legal reference: 441 IAC 91.1(249A)

Medicare beneficiaries who are not deemed eligible for the low-income subsidy may apply for the subsidy by contacting:

- ◆ The Social Security Administration (SSA) by mail, by telephone, on the Internet at www.ssa.gov, or in person; or
- ◆ The Department of Human Services.

The Department will process an application when the applicant insists that the Department make the eligibility determination.

If a potential applicant contacts the local office, advise the person that applying with SSA is the most efficient way to apply and encourage them to apply with SSA. Applying through SSA will generally result in little or no paper verification of information, since information on the SSA application can be electronically verified.

Provide the applicant with Comm. 238, "Cut Your Medical Costs if You Get Medicaid," so the person can self-screen for potential Medicaid eligibility. If the person wants to apply for Medicaid, give the person the *Health Services Application*, form 470-2927 or 470-2927(S), to complete. Process the application for Medicaid eligibility according to normal Medicaid processing requirements.

Ask applicants if they have already applied for the subsidy with SSA and, if so, urge them to wait for a decision from SSA. However, if an applicant insists on filing with the state before an SSA decision, the Department must comply.

Application Forms

The SSA application form is available for on-line, mail, in-person, and phone filing. The application form consists of an attestation regarding a beneficiary's income, family size, and assets.

Provide assistance if the person has a problem in completing the SSA-1020. Because the form is an electronically scannable document, observe the following:

- ◆ **No photocopies.** Do not photocopy the SSA-1020. Photocopying makes the form unscannable and could adversely impact the timeliness of an SSA decision regarding the low-income subsidy. States may obtain additional supplies of the SSA-1020 from the SSA.

- ◆ **No date stamps.** Date stamps interfere with the scannability of the form. Enter a hand-written date in the "For Official Use Only" box on page 2, showing the date the form is completed.

No financial documents are necessary at the time of application. SSA will verify most information through data matches with existing SSA, Internal Revenue Service and other government files.

SSA may need to request some follow-up documentation to resolve discrepancies between data matches and attestations in the application. Individuals will also be contacted if they own property other than their primary residence and the land it is on or if they leave questions on the application unanswered.

Submit completed SSA-1020s to:

Social Security Administration
Wilkes-Barre Data Operations Center
P. O. Box 1020
Wilkes-Barre, PA 18767-9910

IMPORTANT: All subsidy applications taken on the SSA application (SSA-1020) become the responsibility of SSA for the eligibility determination and all subsequent case activity (i.e., notices, appeals, redeterminations).

If a person requests a state determination or refuses to use the SSA application, process the case using Federal Low-Income Subsidy income, family size, and resource rules, but the Department's process for taking applications. The Department is then responsible for notices, appeals, and redeterminations for subsidy cases it has determined using a State application form.

To have the Department handle the application for the extra help, an applicant must complete and sign both:

- ◆ The SSA application, form SSA-1020B-OCR-SM, *Application for Help with Medicare Prescription Drug Plan Costs*, and
- ◆ Form 470-4167, *Addendum to Application for Help with Medicare Prescription Drug Plan Costs*.

See [6-Appendix](#) for form samples and instructions.

Responsibility for LIS Applications

Application Site	Agency Responsible for the Case
SSA	SSA
Department of Human Services, using SSA application	SSA
Department of Human Services, using state application	Department of Human Services
Deemed-(no application)	CMS (based on State data)

Coordinating LIS and MSP Applications

States are not required to screen for and offer MSP enrollment to people who apply for LIS directly with SSA, rather than through a state office. However, CMS is strongly encouraging states to do so, even though the state may not have direct initial contact with these applicants.

States receive data on LIS determinations for coordination (to be sure someone who applies at state has not already been determined LIS eligible by SSA). Data elements States will receive:

- ◆ Subsidy approved (Y/N)
- ◆ Subsidy approval/disapproval date
- ◆ LIS effective date (first day of month of application)
- ◆ Resources over or under LIS limit
- ◆ Income used for determination (individual/couple)
- ◆ Income as percent of federal poverty level
- ◆ Denial reason (no Medicare, not in USA, failure to cooperate, resources too high, income too high)
- ◆ Mailing address

This data will not contain dollar amounts of income or resources.

Iowa will send to persons SSA identifies as subsidy-eligible a letter and Comm. 238, "*Cut Your Medical Costs if You Get Medicaid*," so the person can evaluate potential Medicaid eligibility. Mailings will be handled by Central Office.

Screening LIS Applicants for MSP (QMB/SLMB/QI) Eligibility

In any instance where a state has contact with an applicant for LIS, the state must screen for MSP eligibility and offer to enroll the applicant in its Medicare Savings Program.

For the MSP determination, the state's usual rules apply to all parts of the application process including who may represent the applicant, the interview (if any), screening and clearances, financial criteria, technical requirements, unit size, notices and appeal rights, appeals and fair hearings, and redeterminations. (See 8-F, [People in Medicare Savings Programs.](#))

Federal Medicare saving programs' parameters include:

- ◆ Maximum resources: \$4,000 (individual)/\$6,000 (couple).
- ◆ Maximum income: 135% of the federal poverty level.

If the evidence at the time of application indicates that the applicant would qualify for the Low-Income Subsidy (LIS), the subsidy application should be processed immediately. If the applicant later qualifies for a Medicare savings program (MSP), the applicant will be deemed eligible for the subsidy.

On the other hand, if the evidence indicates that the applicant would qualify for MSP but not qualify for LIS, the MSP application should be processed immediately, since the applicant would be deemed eligible for the subsidy and need not apply.

Use federal rules for the subsidy determination, and the Iowa rules for the MSP determination. If, based on the Iowa's rules, a subsidy applicant is found eligible for QMB, SLMB, or QI (MSP) the applicant becomes deemed eligible for the subsidy, even if the applicant would have not qualified otherwise.

If a subsidy applicant is found eligible for SLMB or QI (MSP) and thus deemed eligible for the subsidy, the state can close its LIS screening. (QMB cases will require additional LIS screening.).

Voluntary Enrollment in LIS

If the applicant is found eligible for a Medicare saving program, the applicant must be offered enrollment, which the applicant is free to decline.

- ◆ If the applicant accepts enrollment, the applicant becomes deemed eligible for the LIS.
 - If the applicant is eligible for SLMB or QI, close the LIS application.
 - If the applicant qualifies for QMB, continue the LIS application process to determine subsidy eligibility for months before QMB eligibility.
- ◆ If the applicant has applied for the LIS using the State application and declines MSP enrollment, continue screening the applicant for eligibility for the Low-Income Subsidy.

LIS eligibility begins as of the first day of the month of application. SLMB and QI eligibility can begin up to three months before the month of application. QMB eligibility begins effective the first day of the month following the month in which eligibility is determined.

Determining Eligibility for Subsidy

Process applications and ongoing eligibility for the low-income subsidy (LIS) using the same procedures as used for processing Medicaid applications. Submit questions about procedures to the DHS, SPIRS Help Desk.

An applicant may withdraw the application at any time before the eligibility determination has been made.

Applicant's Representative

The applicant may be represented by any of the following:

- ◆ A person who is authorized to act on behalf of the applicant;
- ◆ If the applicant is incapacitated or incompetent, someone acting responsibly on the applicant's behalf;
- ◆ A person of the applicant's choice who is requested by the applicant to act as the applicant representative in the application process.

Anyone may help the applicant apply for the subsidy. The person assisting the applicant is required to attest to the accuracy of the information on the application.

Interview

The local office shall conduct an interview if the worker determines one is required in order to determine eligibility.

Screening for Deemed Eligibility

If the applicant is found to be currently enrolled in the Medicare Saving Programs (QMB, SLMB, QI), dispose of the LIS application, as the applicant is deemed eligible for the subsidy and no application is required.

Send the applicant a denial notice on form 470-4199, *Notice of Decision for Extra Help with Prescription Drugs*. (See [6-Appendix](#) for a form sample and instructions.) Select "denial" and "Other" to insert the following notice language:

"Your application for extra help with Medicare prescription drug costs is denied as unnecessary because you receive Medicaid and are automatically eligible for extra help. 42 CFR 423.773(c)."

Clearances

To qualify for Medicare Part D, the beneficiary must:

- ◆ Be entitled to Medicare Part A, enrolled in Medicare Part B, or both; and
- ◆ Reside in the service area of a Part D prescription drug plan.

Conduct the usual SDX/SVES/SOLO clearances to verify the applicant's entitlement and enrollment in Medicare Parts A and B. If no Medicare entitlement or enrollment can be confirmed, deny the LIS application.

If the available data confirm Medicare buy-in in another U.S. jurisdiction, the applicant is deemed eligible for the subsidy and the application for subsidy eligibility should be denied.

Send the applicant a denial notice on form 470-4199, *Notice of Decision for Extra Help with Prescription Drugs*. (See [6-Appendix](#) for a form sample and instructions.) Select "denial" and check "You are not eligible for Medicare" to insert the following notice language:

"Your application for extra help with Medicare prescription drug costs is denied as unnecessary because you are currently receiving the extra help. 42 CFR 423.773(a)"

Inform the previous state of residence of the change of address, and offer an MSP application to the beneficiary, explaining that if the beneficiary qualifies for MSP in Iowa, the beneficiary automatically qualifies for LIS.

Spenddown

If the applicant is pending Medicaid spenddown in the month of application for the subsidy, continue with the LIS determination, using gross income before spenddown.

If the applicant meets Medicaid eligibility during the month of subsidy application, the applicant is deemed eligible for the LIS. The LIS application should be denied. Once deemed, the beneficiary will receive the subsidy for the remainder of the calendar year.

Send the applicant a denial notice on form 470-4199, *Notice of Decision for Extra Help with Prescription Drugs*. (See [6-Appendix](#) for a form sample and instructions.) Select "denial" and "Other" to insert the following notice language:

"Your application for extra help with Medicare prescription drug costs is denied as unnecessary because you have met your Medically spenddown and are automatically eligible for extra help. 42 CFR 423.773(c)."

Family Size

For the purpose of establishing the applicable income standard only, the following persons will be counted in the family size:

- ◆ The applicant;
- ◆ The applicant's spouse, if living with the applicant; and
- ◆ Any persons who are:
 - Related by blood, marriage, or adoption,
 - Living with the applicant and spouse, and
 - Dependent on the applicant or spouse for at least one half of their financial support.

The applicant's income tax records may be useful for determining who has been considered a dependent relative in the past. However, be aware that IRS does not require the dependent family member to live with the applicant, while the subsidy family size criteria does.

Financial Requirements

While rules less restrictive than SSI cannot be used for the LIS determination, if a person qualifies for full Medicaid under a coverage group with less restrictive income guidelines (such as Medicaid for employed people with disabilities), the person would qualify for the subsidy because the person qualifies for Medicaid.

The client must provide needed verification. Allow the client five working days to provide needed verification. Allow additional time if the client is making every effort to secure the verification and more time is requested.

Evaluating Resources

Consider resources of the applicant and the spouse if living with the applicant but not resources of dependent family members. Count liquid resources which are:

- ◆ Cash; and
- ◆ Other resources which can be converted to cash within 20 days, such as:
 - Stocks;
 - Bonds;
 - Mutual fund shares;
 - Promissory notes;
 - Mortgages;
 - Whole life insurance policies;
 - Financial institution accounts, including:
 - Savings;
 - Checking;
 - Time deposits, also known as certificates of deposit;
 - Individual retirement accounts (IRAs);
 - 401 (K) accounts; and
 - And similar items.
- ◆ Real property not contiguous with home property.

The client must provide needed verification. Allow the client five working days to provide needed verification. Allow additional time if the client is making every effort to secure the verification and more time is requested.

Resource Standards

The maximum subsidy resource standards are \$10,210 for one person and \$20,410 for a couple. Resources at or below \$6,120 for an individual and \$9,190 for a couple and income at or below 135% of the federal poverty level will entitle the applicant to the full subsidy.

The SSA subsidy application (SSA-1020) lists \$11,710 for an individual and \$23,410 for a couple to reflect the burial fund exclusion for one person and a couple. These amounts apply only if the applicant or spouse indicates intent to use resources for burial or funeral arrangements. If the applicant or spouse has no intent to use resources for burial or funeral arrangements, the resource standards are \$10,210 for one person and \$20,410 for a couple.

Resource Exclusions

The following resources are not considered in determining LIS eligibility:

- ◆ The applicant's home. For the purposes of this exclusion, a home is any property in which the applicant and spouse have an ownership interest and which serves as their principal place of residence.

There is no restriction on acreage of home property. This property includes the shelter in which an applicant resides, the land on which the shelter is located, and any outbuildings;

- ◆ Non-liquid resources, other than real property. These include, but are not limited to:
 - Household goods and personal effects;
 - Automobiles, trucks, tractors and other vehicles;
 - Machinery and livestock;
 - Noncash business property;
- ◆ Property of a trade or business which is essential to the applicant or spouse's means of self-support;
- ◆ Nonbusiness property which is essential to the applicant or spouse's means of self-support;
- ◆ Stock in regional or village corporations held by natives of Alaska during the 20-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act;
- ◆ Whole life insurance owned by the applicant (or spouse, if any) if the total face value of all the life insurance policies on any person does not exceed \$1,500. When the total face value of all policies exceeds \$1,500, the cash surrender value of all policies is countable;
- ◆ Term life insurance that has no cash surrender value;
- ◆ Restricted, allotted Indian lands, if the Indian owner cannot dispose of the land without the permission of other individuals, the tribe, or an agency of the federal government;
- ◆ Payments or benefits provided under a federal statute other than Title XVI of the Act (SSI) where exclusion is required by the statute;
- ◆ Federal disaster relief assistance received on account of a presidentially declared major disaster, including accumulated interest, or comparable state or local assistance;

- ◆ Funds of \$1,500 for the applicant and \$1,500 for the spouse who lives with the applicant if these funds are intended to be used for funeral or burial expenses of the applicant and spouse;
- ◆ Burial spaces, including burial plots, grave sites, crypts, mausoleums, urns, niches, vaults, headstones, markers, plaques, burial containers, opening and closing of the grave site, and other customary and traditional repositories for the deceased's bodily remains, for the applicant or spouse;
- ◆ Retained retroactive SSI or Social Security benefits for nine months after the month they are received;
- ◆ Certain housing assistance;
- ◆ Refunds of federal income taxes and advances made by an employer relating to an earned income tax credit for the month following the month of receipt;
- ◆ Refunds of child tax credits for nine months after the month they are received;
- ◆ Payments received as compensation incurred or losses suffered as a result of a crime (victims' compensation payments), for nine months beginning with the month following the month of receipt;
- ◆ Relocation assistance from a state or local government, for nine months, beginning with the month following the month of receipt;
- ◆ Dedicated financial institution accounts consisting of past-due benefits for an SSI-eligible individual under age 18;
- ◆ A gift to, or for the benefit of, a person who has not attained 18 years of age and who has a life-threatening condition, from an organization which is exempt from taxation under section 501(a) of the Internal Revenue Code. The resource exclusion applies to any in-kind gift that is not converted to cash, or to a cash gift that does not exceed \$2,000; and
- ◆ Funds received from a government or nongovernmental agency, program, or health insurance policy whose purpose is to provide medical care or medical services or social services and conserved to pay for medical or social services.

Determining Countable Resources

Countable resources are determined as of the first moment of the month of application or redetermination for the subsidy.

Cash received by the applicant or spouse during a month is evaluated under the rules for counting income during the month of receipt. If the applicant or spouse retains the cash until the first moment of the following month, the cash is countable as a resource unless it is otherwise excludable.

Equity Value

Resources, other than cash, are evaluated according to the applicant or spouse's equity in the resources. Count the equity value of real property that is not contiguous with home property.

The equity value of an item is defined as the price for which that item, minus any encumbrances, can reasonably be expected to sell on the open market in the particular geographic area involved. Encumbrances include liens, mortgages, and other obligations against the value of the resource.

Funds Held in Financial Institution Accounts

Funds held in a financial institution account (including savings, checking, and time deposits also known as certificates of deposit) are considered the applicant or spouse's resources if the applicant or spouse owns the account and can use the funds for support and maintenance.

Individually Held Account

If the applicant or spouse is designated as the sole owner by the account title and can withdraw and use funds from that account for support and maintenance, all of the account's funds are the applicant or spouse's resource regardless of the source.

For as long as these conditions are met, presume that the applicant or spouse owns 100 percent of the funds in the account. This presumption is not rebuttable.

Jointly Held Account

If the applicant or spouse is the only subsidy claimant or subsidy recipient who is an account holder on a jointly held account, presume that all of the funds in the account belong to the applicant or spouse.

If more than one subsidy claimant or subsidy recipient are account holders, presume that the funds in the account belong to those individuals in equal shares.

An applicant or spouse who disagrees with that ownership presumption may rebut the presumption. Rebuttal is a procedure which permits a person to furnish evidence and establish that some or all of the funds in the jointly held account do not belong to that person.

Evaluating Income

Income is anything the applicant or spouse receives in cash or in kind that can be used to meet needs for food or shelter. Consider the gross income of the applicant and the spouse if living with the applicant, but not of dependent family members. However, dependent family members are counted in the family size.

Earned Income

Earned income consists of the following types of payments:

- ◆ Wages;
- ◆ Net earnings from self-employment;
- ◆ Payments for services performed in a sheltered workshop or work activities center; and
- ◆ Royalties earned in connection with any publication of a person's work and any honoraria received for services rendered.

Wages

Count wages are at the earliest of the following points:

- ◆ When received;
- ◆ When credited to the person employed; or
- ◆ When set aside for the employee's use.

Net earnings from self-employment are counted on a taxable year basis. Net losses, if any, are deducted from other earned income, but not from unearned income.

Payments for services performed in a sheltered workshop or work activities center are counted when received or set aside for the employee's use.

In-Kind Earned Income

In-kind earned income is counted based on current market value. If the applicant or spouse receives an item that is not fully paid for and is responsible for the balance, only the paid-up value is income to the applicant.

Honoraria and Royalties

Honoraria for services rendered and royalty payments received in connection with any publication of work counts as earned income.

Period Under Consideration

The period for which earned income is counted is the remainder of the calendar year, starting with the month of application for the subsidy. Adjust prospective earned income based on the number of months remaining in the calendar year. The income standard against which the income is measured should be adjusted to reflect the same number of months.

Earned Income Exclusions

Apply exclusions in the order listed below:

- ◆ Refund of Federal income taxes and payments under the Earned Income Tax Credit;
- ◆ The first \$30 of earned income per calendar quarter that is received too irregularly or infrequently to be counted as income;
- ◆ Any portion of the \$20 per month exclusion that has not been excluded from combined unearned income;
- ◆ \$65 per month of the applicant or spouse's earned income;

- ◆ For applicants who are under age 65 and receive a Social Security Disability Insurance benefit based on disability, 16.3% of gross earnings for impairment related work expenses (IRWE);
- ◆ One half of the applicant or spouse's remaining earned income; and
- ◆ For applicants who are under age 65 and receive a Social Security Disability Insurance benefit that is based on blindness, 25% of gross earnings for blind work expenses (BWE).

Unearned Income

Unearned income is all income that is not earned income. Unearned income is counted at the earliest of the following points:

- ◆ When received;
- ◆ When credited to the recipient; or
- ◆ When set aside for the recipient's use.

Unearned income includes, but is not limited to:

- ◆ Social Security;
- ◆ Railroad Retirement;
- ◆ Veterans benefits;
- ◆ Temporary Assistance for Needy Families (TANF);
- ◆ Pensions;
- ◆ Annuities;
- ◆ Alimony and support payments;
- ◆ Rents;
- ◆ Workmen's Compensation;
- ◆ In-kind support and maintenance;
- ◆ Death benefits;
- ◆ Royalties not counted as earned income; and
- ◆ Dividends and interest not otherwise excluded under SSI rules.

Adjustments to Unearned Income

In-Kind Support and Maintenance

In-kind support and maintenance is any food and shelter that is given to the applicant or spouse or received because someone else pays for it. This includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewage, and garbage collection services.

The maximum amount of income countable for in-kind support and maintenance is limited to one third of the monthly Supplemental Security Income (SSI) benefit rate for an individual or a couple, if the applicant's spouse is counted, or the current market value of the support, whichever is lower.

1. Mr. and Mrs. M live rent-free in a home that belongs to their son. The house would otherwise rent for \$900 per month. In 2007, one-third of the SSI benefit for a couple is \$311.33. Therefore, the Ms receive in-kind support valued at \$311.33 per month.
2. Mr. O cannot manage his housing expenses on his income alone. His daughter helps him by paying his electric bill, which averages \$150 per month. In 2007, one-third of the SSI benefit for one person is \$207.66. Therefore, Mr. O receives in-kind support valued at \$150 per month.

Benefit Reductions

When benefits are reduced for overpayments or garnishments, count the gross benefit before deductions.

Mr. P failed to pay income taxes and his Social Security check has been garnished to pay IRS. The gross amount of his benefit is \$1,150 per month; he actually receives \$750. The gross amount (\$1,150) is countable.

Expenses

If part of a payment reflects expenses the applicant/spouse incurred in getting the payment, such as legal fees, or damages, such as medical expenses, incurred because of an accident, reduce the payment by the amount of the expenses. Do not reduce the payment by the amount of personal income taxes owed on the payment.

Dependent Benefits

Subtract from veterans benefits any amount included in the payment for a dependent. If the applicant or spouse is the dependent, count the portion of the benefit attributable to the dependent if the dependent resides with the veteran or receive a separate payment from the Department of Veteran Affairs.

Death Benefits

Subtract from death benefits the expenses of the deceased person's last illness and death paid by the recipient or beneficiary.

Unearned Income Exclusions

The following types of unearned income are not considered for purposes of determining LIS eligibility:

- ◆ Supplemental Security Income (SSI) benefits;
- ◆ Any public agency's refund of taxes on real property or food;
- ◆ Need-based assistance wholly funded by a state or one of its subdivisions, including state supplementation of SSI benefits but not a federal/state grant program such as TANF;
- ◆ Any portion of a grant, scholarship, fellowship, or gift used for paying tuition, fees, or other educational expenses. Any portion set aside or used for food, clothing or shelter is countable;
- ◆ Food which the applicant or spouse raises if it is consumed by their household;
- ◆ Assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any federal statute because of a catastrophe which the President of the United States declares to be a major disaster;
- ◆ Alaska Longevity Bonus payments made to a resident of Alaska who, before October 1, 1985, met the 25-year residency requirement for receipt of such payments in effect before January 1, 1983, and was eligible for SSI;
- ◆ Payments for providing foster care to a child who was placed in the applicant's home by a public or private nonprofit child placement or child care agency;

- ◆ Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become part of the separate burial fund;
- ◆ Home energy assistance (any assistance related to meeting the costs of heating or cooling a home);
- ◆ One-third of support payments made to or for the applicant by an absent parent if the applicant is a child;
- ◆ The first \$20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another and income based on need;
- ◆ Housing assistance-any assistance paid with respect to a dwelling unit under:
 - The United States Housing Act of 1937;
 - The National Housing Act;
 - Section 101 of the Housing and Urban Development Act of 1965;
 - Title V of the Housing Act of 1949; or
 - Section 202(h) of the Housing Act of 1959;
- ◆ Any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement;
- ◆ Gift of a domestic travel ticket received by the applicant or their spouse and not converted to cash;
- ◆ Payments made to the applicant or their spouse from a fund established by the State to aid victims of crime;
- ◆ Relocation assistance provided to the applicant or spouse by the state or local government that is comparable to relocation assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
- ◆ Hostile-fire pay received from one of the uniformed services;
- ◆ The first \$60 of unearned income received per calendar quarter that is received too irregularly or infrequently to be counted as income; or
- ◆ Any dividends or interest earned on countable resources, any dividends or interest earned on resources excluded under a federal statute other than the Social Security Act, and any dividends or interest excluded under the Social Security Protection Act of 2004.

Verifications for the Low-Income Subsidy

Legal reference: 441 IAC 91.3(1) and 91.3(2)

You may require submission of statements from financial institutions for the application to be considered complete. The client must provide needed verification. Allow the client five working days to provide needed verification. Allow additional time if the client is making every effort to secure the verification and more time is requested.

Calculating Low-Income Subsidy Eligibility

To calculate eligibility for the low-income subsidy:

- Using the family size reported by the applicant and the applicant's countable net income, determine where the applicant and spouse, if any, fall on the applicable poverty level table. See 8-F, [Qualified Medicare Beneficiaries \(QMBs\)](#), for the current federal poverty levels for an individual and a couple.
- Using the percent of the federal poverty level (FPL) and the applicant and spouse's countable resources, find the subsidy code (A through F) on the subsidy calculation table for one person or a couple.

Subsidy Calculation for One Person

Countable Resources in \$	≤ 135% FPL	> 135% to ≤ 140% FPL	> 140% to ≤ 145% FPL	> 145% to ≤ 150% FPL	> 150% FPL
≤ \$6,120	A	C	D	E	F
> \$6,120 to ≤ \$10,210	B	C	D	E	F
> \$10,210	F	F	F	F	F

Subsidy Calculation for a Couple

Countable Resources in \$	≤ 135% FPL	> 135% to ≤ 140% FPL	> 140% to ≤ 145% FPL	> 145% to ≤ 150% FPL	> 150% FPL
≤ \$9,190	A	C	D	E	F
> \$9,190 to ≤ \$20,410	B	C	D	E	F
> \$20,410	F	F	F	F	F

3. Using the subsidy code, identify the applicable benefits on the subsidy benefits table.

Subsidy Benefits

Subsidy	Subsidized Monthly Premium	Yearly Deductible	Precatastrophic Copayment per Prescription	Coverage Gap? Y/N	Catastrophic Copayment per Prescription
A	100%*	\$0	\$2.15/\$5.35	N	\$0
B	100%*	\$53	15%	N	\$2.15/\$5.35
C	75%	\$53	15%	N	\$2.15/\$5.35
D	50%	\$53	15%	N	\$2.15/\$5.35
E	25%	\$53	15%	N	\$2.15/\$5.35
F (no subsidy)	0%	\$265	25%	Y	@5%

*Percentage is the greater of the low income benchmark premium amount or the lowest prescription drug plan premium for basic coverage in the region.

NOTE: The SSA Calculator Tool may be used for this calculation. This resource may be found at www.ssa.gov under "Medicare Outreach."

Mr. and Mrs. S are Medicare beneficiaries who are raising their 15-year-old grandson. Based on the poverty level guidelines, their income falls below 135% of the federal poverty level. They have \$18,000 in countable resources.

Using the percentage of the federal poverty level and the total countable resources, find the subsidy code on the subsidy calculation table for couples. The correct answer is "B."

Transpose the percentage of premium level for "B" onto the approval notice.

Periods of Eligibility

The effective period of eligibility for the low-income subsidy based on a state application is as follows:

- ◆ Initial eligibility determinations are effective as of the first day of the month of application and remain in effect for one year.
- ◆ Redeterminations must be made in the same manner and frequency as redeterminations Medicaid eligibility.

Mr. D files a subsidy application in March 2011. If he qualifies, his subsidy will be effective March 1, 2011.

Notices

If a state application is used, the state must provide a notice of decision. All notices must be adequate and timely as require for Medicaid.

Use form 470-4199, *Notice of Decision for Extra Help with Prescription Drugs*, to notify the client of decisions made on the eligibility for the extra help. A template for this form is available on eForms. See [6-Appendix](#) for a form sample and instructions on inserting notice language.

Approval Notice

If you determine that an applicant is eligible for LIS, send an approval notice containing the following required data:

- ◆ Application date;
- ◆ Regulatory basis for the decision, if required by the State;
- ◆ Description of how the subsidy was calculated; what income, family size, and resources were used;
- ◆ Premium percentage;
- ◆ Effective date of eligibility;
- ◆ Who made the decision and how to contact them;
- ◆ Appeal rights and procedures; and
- ◆ Reminder to apply for a prescription drug plan.

Denial Notice

If you determine that an applicant is ineligible for LIS, send a denial notice containing the following required data:

- ◆ Application date;
- ◆ Reason for denial:
 - Not Medicare-eligible;
 - Failure to complete the application process;
 - Income exceeds 150% of the federal poverty level;
 - Resources exceed \$11,710 for one person or \$23,410 for a couple;
 - Not a resident of Iowa;
 - Not a resident of the United States or incarcerated.
- ◆ Legal reference for decision;
- ◆ Description of how the cancellation was calculated; what income, family size, and resources were used;
- ◆ Effective date of cancellation;
- ◆ Who made the decision and how to contact them;
- ◆ Appeal rights and procedures; and
- ◆ Depending on the cancellation reason, a reminder that they will still use their prescription drug plan.

Cancellation Notice

If you determined that a person is no longer eligible for LIS, send a cancellation notice containing the following required data:

- ◆ Reason for cancellation:
 - Not Medicare-eligible;
 - Failed to complete the redetermination process;
 - Income exceeds 150% of the federal poverty level;
 - Resources exceed \$11,710 for an individual or \$23,410 for a couple;
 - Not a resident of Iowa;
 - Not a resident of the United States or incarcerated.
- ◆ Legal reference for cancellation;

- ◆ Description of how the cancellation was calculated; what income, family size, and resources were used;
- ◆ Effective date of cancellation;
- ◆ Who made the decision and how to contact them;
- ◆ Appeal rights and procedures; and
- ◆ Depending on the cancellation reason, a reminder that they will still use their prescription drug plan.

Change Notice

If you determine that an individual's eligibility for LIS has changed, send a change notice containing the following required data:

- ◆ Reason in change in subsidy level;
- ◆ Legal reference for change;
- ◆ New premium percentage;
- ◆ Description of how the change was calculated; what income, family size, and resources were used;
- ◆ Effective date of change;
- ◆ Who made the decision and how to contact them;
- ◆ Appeal rights and procedures; and
- ◆ Reminder that they will still use their prescription drug plan but that their costs within the plan have changed.

Interim Changes (Subsidy-Changing Events)

Legal reference: 441 IAC 91.6(249A)

LIS recipients must report the following changes within in ten days:

- ◆ Care of dependents
- ◆ Household composition
- ◆ Household income
- ◆ Household resources
- ◆ Marital status
- ◆ Medicare eligibility or enrollment
- ◆ Place of residence

Changes in level of eligibility shall be effective the month following the month of change.

Beneficiaries who become eligible for Medicaid, SSI, QMB, SLMB, and QI after being found eligible for the subsidy join the deemed population. Close the ongoing subsidy case but maintaining the Medicaid case. CMS will notify the beneficiary that LIS eligibility is now deemed.

CMS will also redetermine subsidy eligibility of the deemed eligibles on a yearly basis. If a beneficiary subsequently loses deemed status, CMS will notify the beneficiary of the need to apply at SSA or the State Medicaid agency so that the beneficiary can retain eligibility for the low-income subsidy.

Redetermination

Legal reference: 441 IAC 91.7(249A)

Redetermine subsidy eligibility in the same manner and frequency as redeterminations are required for Medicaid. Conduct reviews shall be on at least an annual basis. Reviews will not appear on the 607 or 609 review reports. Central office staff will notify workers when reviews are due.

Appeals and Fair Hearings

Legal reference: 441 IAC 91.8(249A)

The subsidy applicant may appeal the Low-Income Subsidy determination made by the state according to the Medicaid appeal procedures. See [1-E](#) for details.

SSA will be responsible for appeals of decisions made by SSA, including decisions made on SSA applications forwarded to SSA by the State.

Multiple Determinations for the Same Applicant

Legal reference: 42 CFR § 423.774

The Department may not know if a subsidy application has also been filed at SSA. In the case of multiple determinations based on applications in different months, the later application is void if the applicant has received a positive subsidy determination on the earlier application with the state or SSA. This is so even if the earlier decision is a partial subsidy and the later decision is a full subsidy.

If two approvals occur in the same month, the SSA decision takes precedence, even if it provides a lower level of subsidy.

All decisions may be appealed, including denials, effective dates, and partial subsidies, with the agency that is responsible for the decision.

Precedence of LIS Decisions

<u>Scenario</u>	<u>SSA</u>	<u>State</u>	<u>Outcome</u>
1	Denial	Approval	Approval is official determination. Beneficiary may appeal either decision.
2	Approval	Denial	Approval is official determination. Beneficiary may appeal either decision.
3	Denial	Denial	The beneficiary may appeal either decision. If both are appealed and overturned, see scenarios 4 and 5.
4	Approval (different month)	Approval (different month)	If the subsidy effective dates are in different months, the decision with the earlier effective date is the official determination. The second decision is void.
5	Approval (same month)	Approval (same month)	If the subsidy effective dates are the same, the SSA decision is the official determination. The beneficiary may appeal either decision.