

CHANGE NOTICE FOR MANUAL NO. 21-05, MEDICARE PART D LOW INCOME SUBSIDY

DATE: JUNE 15, 2005

Manual: Aged, Blind, and Disabled Medicaid

Change No: 21-05

To: County Directors of Social Services

Effective: July 1, 2005

Make the following change(s)

I. BACKGROUND

The purpose of this change notice is to issue new policy regarding the Medicare Part D Low Income Subsidy (LIS). The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established the Medicare Prescription Drug Program, also known as Medicare Part D. The Medicare Prescription Drug Program consists of two parts: 1) enrollment into a Prescription Drug Plan (PDP) and 2) a Low Income Subsidy (LIS).

The Medicare Prescription Drug Program provides assistance with prescription drugs for all Medicare beneficiaries. The monthly premium is expected to be about \$37. The basic coverage includes an annual deductible of \$250 and cost-sharing or co-payments of 25% up to \$2,250 in total drug costs. The beneficiary is then responsible for 100% of prescription drug costs until the total cost reaches \$5,100. The gap in coverage where the beneficiary is responsible for 100% of drug costs is referred to as the "donut hole". After a beneficiary reaches the catastrophic limit of \$5,100 in total drug costs, the co-pay for prescriptions is 5%.

The LIS provides additional assistance for Medicare beneficiaries with income less than 150% of the Federal Poverty Level. The LIS benefits include a reduction in the deductible and co-pays for prescriptions and assistance with the premium paid to the PDP. The premium assistance may be 100%, 75%, 50% or 25% of the premium amount for a basic plan, depending on income.

Beginning January 1, 2006, Medicaid will no longer provide prescription coverage for Medicare beneficiaries who also receive Medicaid. Individuals authorized for Medicaid in any aid program/category except M-WD and NCHC will be automatically eligible for the LIS. They must enroll in a PDP to get their prescription benefit and take advantage of the LIS. Current full Medicaid recipients with Medicare will be automatically enrolled in a PDP beginning in mid-November effective January 1, 2006. They will have the opportunity to change to a different PDP if they choose. Individuals who receive MQB-Q/B/E are also automatically eligible for the LIS and must enroll with a PDP by May 15, 2006, or they will be automatically enrolled. However, if these individuals enroll in a

prescription plan before January, they will have help with prescription coverage beginning January 1.

Individuals who are not automatically eligible for the LIS may apply for the extra help at SSA or Medicaid offices. SSA has developed an automated system for the application process. The LIS application is available on-line at www.socialsecurity.gov on July 1. There is also a scannable paper application, SSA-1020, Application for Help with Medicare Prescription Drug Plan Costs. The Medicaid office must offer to take an LIS application from any Medicare beneficiary appearing at DSS expressing medical or financial need unless the individual is already a Medicaid recipient. You may not refer an individual to SSA to apply for the LIS. You must also evaluate the beneficiary for eligibility in all Medicaid programs, including MQB. However, unless the applicant insists that dss determine eligibility for the LIS application, you will forward the LIS application electronically or mail it to SSA for processing.

For information about prescription drug plans or for assistance with enrolling in a plan, a Medicare beneficiary may visit www.medicare.gov or call toll-free at 1-800-MEDICARE (1-800-633-4227) or the State Seniors' Health Insurance Information Program, SHIP, at 1-800-443-9354.

II. CONTENT OF CHANGE

A. MA-2310, *Taking the LIS Application*, is being added to the manual. This section provides the policy and procedures for taking an application for the LIS.

1. A Medicare beneficiary may apply for the LIS at the local department of social services or at SSA.
2. The dss must offer to take an LIS application for any Medicare beneficiary who appears at the dss requesting medical or financial assistance or requesting to apply for the LIS.
3. The dss may not refer an individual to SSA to apply for the LIS if he appears at the dss requesting assistance with the LIS.

The dss must treat the individual as requesting medical or financial assistance. All procedures for Medicaid applications must be followed.

4. Any individual who wishes to apply for the LIS at DSS must be evaluated for all Medicaid programs. This is required in the federal regulations.
5. SSA will process all subsidy applications taken by DSS that are generated on-line or via the paper application unless the applicant insists that DSS process the application.
The caseworker does not offer the applicant the option of processing the LIS application at DSS, but must offer to take the LIS application and forward it to SSA. SSA, CMS and DMA strongly encourage the use of the automated system developed by SSA.

B. MA-2311, *Processing the LIS Application*, is being added to the manual. This section provides the policy and procedures for processing an LIS application if the Medicare beneficiary insists that the dss determine eligibility.

1. An individual must be entitled to Medicare Part A and/or enrolled in Part B to be eligible for the LIS. He must be receiving Medicare benefits and should have a Medicare card.
2. An individual must have income less than 150% of the federal poverty level.
3. An individual must have resources less than \$10,000 for a single person or \$20,000 for a couple.
4. The caseworker must follow all procedures contained in MA-2303, *Verification Requirements for Applications*, and MA-2304, *Processing the Application*, unless otherwise specified in the LIS policy. MA-2311 does not apply to applications taken by DSS and forwarded to SSA.
5. The caseworker must follow all policy and procedures in MA-2230, *Financial Resources*, and MA-2250, *Income*, unless otherwise specified in the LIS policy. MA-2311 does not apply to applications taken by DSS and forwarded to SSA.

III. MANUAL PROCESS FOR DSS APPROVALS/DENIALS

The dss must determine eligibility for the LIS if the client insists. It is to the client's advantage for DSS to forward the LIS application to SSA for processing. In the majority of cases, the applicant will receive a determination from SSA within 2 – 3 weeks and will not have to provide any documentation other than the on-line or paper application.

If the dss processes the application because the applicant insists, all Medicaid application and verification requirements must be followed. Once eligibility is determined, data must be sent to DMA. The data is then manually keyed to a file that is submitted monthly to CMS. This could possibly delay the individual's benefit.

IV. EFFECTIVE DATE AND IMPLEMENTATION

This policy is effective July 1, 2005.

IV. MAINTENANCE OF MANUAL

Remove: Nothing to remove.

Insert: [MA-2310](#), *Taking the LIS Application*, and Figure 1.

Remove: Nothing to remove.

Insert: [MA-2311](#), *LIS Processing and Case Maintenance*, and Figures 1 – 5.

If you have any questions, please contact your Medicaid Program Representative.

Mark Benton
Interim Director

[This material was researched and written by Carolyn McClanahan, Medicaid Program Representative.]