DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, MD 21244-1850

MEDICARE ENROLLMENT & APPEALS GROUP

DATE: July 20, 2016

TO: Part D Sponsors

FROM: Michael Crochunis
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SUBJECT: Re-Determination of Part D Low-Income Subsidy Eligibility for 2017

The purpose of this memorandum is to provide organizations with information and guidance about:

- The process used by the Centers for Medicare & Medicaid Services (CMS) and the Social Security Administration (SSA) to re-determine Medicare beneficiaries' low-income subsidy (LIS) eligibility;
- An optional grace period for individuals who will no longer automatically qualify for the Part D LIS in 2017;
- A special enrollment period (SEP) for individuals who lose their LIS eligibility;
- CMS' expectations regarding Part D sponsors' responsibility for conducting outreach to members who no longer automatically qualify for LIS in 2017 and steps sponsors may take to ease their members' transition; and
- Two files from CMS to all Part D sponsors identifying individuals who CMS has notified about their loss of LIS in 2017.

Background

The Part D LIS provides extra help for people with Medicare who have limited income and resources by helping to pay their Medicare Prescription Drug Benefit costs (plan monthly premiums, co-payments, and the annual deductible). Certain groups of Medicare beneficiaries automatically qualify (are deemed eligible) for LIS, including: full-benefit dual eligible individuals, partial dual eligible individuals (those who belong to a Medicare Savings Program), and people who receive Supplemental Security Income (SSI) benefits, but not Medicaid. Other individuals with limited incomes and resources who do not automatically qualify can apply for the subsidy and have their LIS eligibility determined by either SSA or their State Medicaid Agency. Table 1, on the following page, provides an overview of how people qualify for LIS.

Table 1. Overview of How People Qualify For LIS

People with Medicare and--	Basis	Data Source	Changes During the Year
Medicaid benefits • Full Medicaid benefits • Medicare Savings Program	Automatically qualify	State files	• Qualify for a full calendar year • Generally, only favorable changes will occur
SSI benefits		SSA	
Limited income and resources	Must apply	SSA (almost all) or States	• Some events can impact status throughout the year • Extra help can increase, decrease, or terminate

CMS' Process for Re-Determining LIS Eligibility for People Who Automatically Qualify

- July 2016 – CMS will begin to identify LIS eligible individuals who will continue to automatically qualify for LIS in 2017. However, if CMS determines during the re-determination process that an individual no longer qualifies for LIS, the individual's subsidy will end on December 31, 2016.
- Mid-September 2016 – Individuals who will no longer qualify for LIS automatically in 2017 will receive, in a joint mailing from CMS and SSA, a personalized letter on grey paper explaining this loss of LIS and an SSA application for extra help to complete and return in an enclosed postage-paid envelope. If a person's situation subsequently changes so that s/he again automatically qualifies for extra help, CMS will send another notice letting him/her know that s/he qualifies.
- Early October 2016 – Individuals who will continue to qualify automatically for LIS in 2017, but will have a change in their co-payment level for 2017, will receive a personalized letter on orange paper from CMS outlining the changes that will be effective January 1, 2017.

SSA Process for Re-Determining LIS Eligibility for People Who Apply

Individuals who apply and qualify (are determined eligible) for LIS may be contacted by SSA to have their status reviewed. These reviews are done each year, usually in mid-September. Individuals selected for review will be sent a form, "Social Security Administration Review of Your Eligibility for Extra Help" and will have 30 days to complete and return this form to SSA. It is important to note that individuals who do not return the form may have their LIS status terminated at the end of the year. SSA may decide that individuals selected for review--

- Have no change in the amount of extra help they receive;
- Have an increase in the amount of extra help they receive;
- Have a decrease in the amount of extra help they receive; or
- No longer qualify for extra help.

SSA will send a letter to the beneficiary that explains the decision and his/her appeal rights. Individuals not selected for review will have no change in their status.

The materials referenced above, as well as more detailed information on the SSA re-determination process, are available on the SSA website at http://www.ssa.gov/prescriptionhelp/.

Optional Grace Period for Individuals Who No Longer Automatically Qualify for the Part D LIS in 2017

Part D sponsors may offer up to a 3-month grace period for the collection of premiums and cost sharing to individuals who will no longer automatically qualify for the LIS in 2017, but can demonstrate that they have applied.

As established in Section 40.2.8 of Chapter 13 of the Prescription Drug Benefit Prescription Drug Benefit Manual, Part D sponsors choosing to offer this grace period must make it available to all such individuals who qualified for LIS in 2016. If, after the grace period has expired, the individual still does not appear as LIS eligible according to CMS' records or has not submitted Best Available Evidence (BAE) to the plan, sponsors are to recoup unpaid premiums or cost sharing amounts consistent with existing CMS guidance as found in Chapter 13 of the PDP Manual. (Chapter 13 can be found at https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html)

Sponsors must obtain confirmation, either verbally or in writing that an individual has applied for LIS prior to granting the grace period. In other words, the grace period may not be applied automatically to all individuals losing LIS; instead, sponsors may apply the grace period only if an LIS application has been submitted. For example, sponsors could send a letter to affected members instructing them to call the sponsor if they are interested in the grace period. Any communication with the members should advise them of the potential for retroactive liability for higher premiums and cost sharing as of January 1, 2017. Communication should also include information regarding the SEP for loss of deemed status (described below) and the need to take action by March 31, 2017, if they do not regain LIS status and wish to change plans. Sponsors that develop notices for this purpose should submit these notices to CMS for review and approval, consistent with Medicare marketing guidelines.

Best Available Evidence and Re-Deeming

Please note that sponsors are to continue following current BAE policy for individuals who are losing deemed status in 2017. For guidance about CMS' BAE policy, see Section 70.5 of Chapter 13 of the Prescription Drug Benefit Manual (https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html).

Special Enrollment Period

Individuals who lose their LIS eligibility effective January 1, 2017, including individuals who no longer automatically qualify for extra help, have an SEP beginning January 1, 2017, through March 31, 2017. They can use this SEP to make a one-time Part D election. Additional information regarding this SEP can be found in the Medicare Advantage (MA) and Prescription Drug Benefit enrollment guidance available at the following locations:

- Prescription Drug Benefit Enrollment Guidance: http://www.cms.gov/Medicare/Eligibility-and-enrollment/MedicarePresDrugEligEnrol/index.html
- MA Enrollment Guidance: http://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/index.html

Part D Sponsor Responsibilities

As in the past, CMS expects Part D sponsors to reach out by phone or mail to every member who, beginning in 2017, will no longer qualify automatically for extra help. Part D sponsors should encourage individuals to apply for LIS and help them through the process. For example, we expect that, upon request, Part D sponsors should be able to assist individuals with completing the LIS application.

In support of this effort, CMS is identifying for each Part D sponsor those individuals whom CMS is notifying by mail, and providing an outbound script (Attachment A) and model notice (Attachment B) for sponsors to use. Sponsors that will be using the model script or notice are instructed to submit the material under the following marketing material categories:

- The **script** should be submitted under 6017 – Other Scripts
- The **letter** should be submitted under 10001 – Low-Income Subsidy – LIS Letters

If the document is submitted as a File & Use piece (where the model is used without modification), CMS will waive the 5-calendar day waiting period before the documents can be used or distributed.

Part D sponsors should update scripting for inbound calls where appropriate. Part D sponsors may also provide a link on their own plan websites to the SSA website, which includes general information about LIS and the application itself. https://www.ssa.gov/medicare/prescriptionhelp/

Systems Notification

As mentioned above, CMS will be reporting to Part D plan sponsors those members who are being notified about their loss of LIS deemed status. Part D sponsors will receive two files; both entitled *Loss of Subsidy Data File*, containing one record for each affected beneficiary. The first file, which will be sent in early September, includes those members who will be receiving CMS' grey "undeemed" letter. The file is informational only and should be used to identify individuals who plans should contact. This file should not be used to change active LIS status definitions.

The second file will be sent in December and should be used to change active LIS status definitions. The file format for plans can found in Section F.29 of the Medicare Advantage and Prescription Drug Benefit Communication User Guide Appendices, at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.html.

The naming conventions for these files will be:

Internet Server:
P.Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst

Gentran:
P.Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst.pn

Connect:Direct (Mainframe):
zzzzzzzz.Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst

Connect:Direct (Non-Mainframe):
[directory]Rxxxxx.EOYLOSD.Dyymmdd.Thhmmsst

Also, because CMS has already started re-determining (re-deeming) LIS eligibility, Part D sponsors should have seen LIS periods for some members dated January 1, 2017, to December 31, 2017, beginning in July. This means that these members will be automatically qualified for LIS for the coming plan year. Therefore, Part D sponsors should note that:

- Because the re-deeming process continues throughout the fall, members who received the grey letter and appeared on the September file may later be determined LIS eligible. Therefore, if the plan conducts outreach to the member, with either the outbound script or the model letter, Part D sponsors should reconcile the September file regularly with the daily Transaction Reply Report (DTRR) to ensure that these individuals are excluded from their outreach efforts.
- Even though plans have been notified (starting in July) that an individual has been re-deemed for LIS for the following calendar year, the LIS Rider conveying the following year's status need **not be sent** until the combined Annual Notice of Change/Evidence of Coverage (ANOC/EOC) is sent. If a sponsor receives notification of an individual's re-deeming **after** it mails the combined ANOC/EOC, the sponsor must send an LIS Rider within 30 days of the notification. These instructions are outlined in Section 70.2 of Chapter 13 of the Prescription Drug Benefit Manual.

Points of Contact

For policy questions about LIS eligibility, including the annual process for re-determination, please contact Stephen Ludwig via e-mail at Stephen.Ludwig@cms.hhs.gov. For technical questions pertaining to this notification, please contact the MMA Help Desk at 1-800-927-8069 or via e-mail at: mapdhelp@cms.hhs.gov.

ATTACHMENT A – Model Outbound Script for Calls to Those Losing Deemed Status - #6017

7/2016

[Note to Part D sponsors: italicized, bracketed language is optional.]

Hello, my name is <name> and I am calling from <plan name>.

We're working with Medicare to help you save on your Medicare prescription drug coverage. You recently received a grey letter from Medicare telling you that you received this help automatically in 2016, but you will need to apply to receive it beginning January 1, 2017. We are contacting you to encourage you to apply for the extra help as soon as possible.

We'd like to ask you a couple of questions. Your participation is voluntary and does not affect your membership in <plan name>.

Have you already completed and mailed an application for extra help?

> [If "yes", end call] Thank you for your membership in <plan name>. If you have any questions after this call, you may call us at <toll-free number><days and hours of operation>. TTY users should call <toll-free TTY number>.
>
> [If "no"]
> The easiest way to apply is by filling out and mailing the application that is included in your grey letter from Medicare.

[In addition, we can:]

[Describe additional voluntary activities applicable to your organization such as:
- *Help you fill out the form; or*
- *Help you complete an application on-line (by computer).]*

Would you like to apply?

> [If "yes"] Are you interested in having:
> *[Describe any activities applicable to your organization:*
> - *An application form mailed to you?*
> - *A representative of <plan name> call you by telephone to help you with the form?*
> - *Hearing about our premium/cost sharing grace period program?]*
>
> [If "no"] Again, there is no cost or obligation to apply. We just wanted to encourage you to apply as soon as possible. If you are approved, your extra help will be continued in 2017. If you change your mind and would like our help, call us at <customer service number>.

<Contract#, Material ID, CMS Approval Date (if Applicable)

Let me confirm your choice:

[*State one of the following as applicable*:

- *You want an application form mailed to you;*
- *You want help by telephone to complete the form;*
- *You are interested in hearing about the premium/cost sharing grace period.]*

Thank you for considering an application for extra help. <Plan name> values your membership and is ready to help you apply for extra help with your prescription drug costs. If you have any questions, please call us at <customer service number>.

ATTACHMENT B - Model Notice for Beneficiaries Losing Deemed Status – #10001

7/2016

[Note to Part D sponsors: italicized, bracketed language is optional.]

<Date>

Dear <Name of Member>:

This is an important reminder that you need to apply as soon as possible for extra help with your prescription drug costs in 2017. You recently received a grey letter from Medicare telling you that although you received this help automatically in 2016, you will no longer automatically qualify to receive it beginning January 1, 2017.

You won't automatically qualify for extra help next year because you no longer:

- Qualify for Medicaid;
- Get help from your state Medicaid program to pay your Medicare Part A and/or Part B premiums (belong to a Medicare Savings Program); OR
- Get Supplemental Security Income (SSI) benefits, but not Medicaid.

You may still qualify for extra help, but you must apply to find out. **So, we are contacting you to encourage you to apply for the extra help now.**

The easiest way to apply is by filling out and mailing the application that was included in your grey letter from Medicare. Other steps you can take are:

- For questions about extra help with your prescription drug costs or if you need assistance completing the application:
  - Call the Social Security Administration (SSA) at 1-800-772-1213. (TTY users call 1-800-325-0778) between 7:00 a.m. – 7:00 p.m. Monday through Friday.
  - You can also fill out the application at www.socialsecurity.gov on the web.
- To get another copy of the application by mail, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call a State Health Insurance Program (SHIP) in your area for free personalized health insurance counseling. See your "Medicare & You" handbook or call 1-800-MEDICARE for their telephone number.

[In addition, we can:]

[Describe any voluntary activities applicable to your organization, such as:

- *Help filling out the form.*
- *Help completing an application on-line (by computer).*
- *Availability of premium/cost sharing grace period.]*

<Contract#, Material ID, CMS Approval Date (if Applicable)

If you don't qualify for extra help, there are still ways you might be able to save on your drug costs.

- Your state may have programs that provide help paying your prescription drug costs. Contact your State Medical Assistance (Medicaid) office for more information. Call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web for their telephone number. TTY users should call 1-877-486-2048.
- *[insert, if applicable: We offer (an) other plan(s) that may lower your Prescription Drug Benefit costs]*

If you have any questions, please call us at <toll-free number><days and hours of operation>. TTY users should call <toll-free TTY number>.