

Due Process in the Medicare Prescription Drug Benefit

Texas Legal Services Center

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Legal Framework

- Medicare Prescription Drug, Improvement, and Modernization Act of 2003
 - Public Law 108-173
- Took effect December 8, 2003
- Became Section 1860D of the Social Security Act
- Codified at 42 United States Code Section 1395w-101 through 152

Legal Framework

- The basic Medicare Part D benefit is set forth at 42 U.S.C. §1395W-102(b) and is called “standard prescription drug coverage”

Subpart C -- Beneficiary Protections

- The Prescription Drug Plan (PDP) must have a contracted network of pharmacies, so that:
 - At least 90% of the urban enrollees have a network pharmacy within 2 miles
 - At least 90% of suburban enrollees have a network pharmacy within 5 miles
 - At least 70% of rural enrollees have a network pharmacy within 15 miles

42 CFR §423.120(a)(1)(i),(ii),(iii)

Subpart C -- Beneficiary Protections

- The PDP must permit its enrollees to receive Part D benefits (including a 90-day supply) at any of its network pharmacies
- The PDP can have “preferred” pharmacies at which the copayments are reduced

42 CFR §423.120(a)(9),(10)

Subpart C -- Beneficiary Protections

- The PDP is permitted to use a formulary
- The formulary must meet standards as to:
 - Development and revision, Adequacy of benefits
 - Transition process for new enrollees, Limitations on changes in therapeutic classification, Notice of changes
 - Limitations on formulary changes prior to the start of a contract year, and Provider and patient education

42 CFR §423.120(b)

Subpart C -- Beneficiary Protections

- The formulary standards as to development and revision provide:
 - The formulary must be developed and reviewed by a pharmacy and therapeutic committee, with a majority of its members being practicing physicians and/or practicing pharmacists
 - One physician and one pharmacist must be experts regarding care of elderly persons or persons with disabilities
 - The regulation provides details concerning how decisions must be made, such as being based on scientific evidence

42 CFR §423.120(b)(1)

Subpart C -- Beneficiary Protections

- The formulary standards as to provision of an adequate benefit provide:
 - The formulary must include within each therapeutic category and class of Part D drugs at least two Part D drugs unless that category or class has only one Part D drug in it

42 CFR §423.120(b)(2)(i)

Subpart C -- Beneficiary Protections

- The formulary standards as to provision of an adequate benefit further provide:
 - That the two Part D drugs in a category or class cannot be therapeutically equivalent and bioequivalent, and for each drug there must be different strengths and dosages offered

42 CFR §423.120(b)(2)(i)

Subpart C -- Beneficiary Protections

- The formulary standards as to provision of an adequate benefit further provide:
 - That if only two drugs are available in a category or class and one is clinically superior, the PDP can, with CMS approval, offer only the superior drug

42 CFR §423.120(b)(2)(ii)

Subpart C -- Beneficiary Protections

- The formulary standards as to provision of an adequate benefit further provide:
 - That the PDP must include adequate coverage of the types of drugs most commonly needed by Part D enrollees

42 CFR §423.120(b)(2)(iii)

Subpart C -- Beneficiary Protections

- The formulary standards as to a transition process provide:
 - That the PDP must have an appropriate transition process, consistent with CMS guidelines, for new enrollees who are prescribed Part D drugs that are not on the Plan's formulary

42 CFR §423.120(b)(3)

Subpart C -- Beneficiary Protections

- The formulary standards as to notice regarding formulary changes (removal of a drug from the formulary or change in preferred or tiered status of a covered drug) require:
 - 60 days' advance notice to CMS, authorized prescribers, and network pharmacies and pharmacists

42 CFR §423.120(b)(5)(1)

Subpart C -- Beneficiary Protections

- The formulary standards as to notice regarding formulary changes (removal of a drug from the formulary or change in preferred or tiered status of a covered drug) require:
 - 60 days' direct advance written notice to affected enrollees, or providing enrollees a 60-day supply of the drug on same terms as before
42 CFR §423.120(b)(5)(1)(A),(B)

Subpart C -- Beneficiary Protections

- The written notice regarding formulary changes must contain:
 - The name of the affected drug;
 - Whether the Plan is removing the drug or rather is changing its preferred or tiered status;
 - The reasons for the change;
 - Alternative drugs in the same therapeutic category or class; and
 - The means by which the enrollee can obtain a coverage determination or an exception

42 CFR §423.120(b)(5)(1)(A),(B)

Subpart C -- Beneficiary Protections

- The formulary standards as to notice before changes allow the PDP to remove any drug found unsafe by the Food and Drug Administration or any drug removed from the market by the manufacturer
- In such cases, retrospective notice is to be provided to enrollees

42 CFR §423.120(b)(5)(iii)

Subpart C -- Beneficiary Protections

- The formulary standards as to limitation on formulary changes prior to the beginning of a contract year forbid formulary changes (removal of a covered Part D drug or changes in preferred or tiered status) between November 15th and 60 days after the start of the plan contract year associated with the annual coordinated election period (Unsafe or recalled drugs can be removed)

42 CFR §423.120(b)(6)

Subpart C -- Beneficiary Protections

- The PDP Plan must provide for out-of-network access to covered Part D drugs
 - This is for the situation when the enrollee cannot reasonably be expected to use a network pharmacy, and does not routinely use an out-of-network pharmacy

42 CFR §423.124(a)(1)(i),(ii)

Subpart C -- Beneficiary Protections

- The PDP Plan must ensure that Part D enrollees have adequate access to vaccines and other covered Part D drugs that appropriately can be dispensed and administered in a doctor's office

42 CFR §423.124(a)(2)

Subpart C -- Beneficiary Protections

- The PDP Plan must disseminate information to the enrollees on the Plan
 - In a clear, accurate, and standardized form,
 - At the time of enrollment and at least annually thereafter

42 CFR §423.128

Subpart C -- Beneficiary Protections

- The PDP Plan's information to the enrollees on the Plan, must address
 - The service area, benefits (premiums, cost-sharing), the formulary (including a list of drugs on the formulary), access, out-of-network coverage, grievance, coverage determinations, and appeals procedures, quality assurance policies and procedures, and disenrollment rights and responsibilities

42 CFR §423.128(b)

Subpart C -- Beneficiary Protections

- The written explanation of benefits must:
 - List the item or service for which payment was made and the amount of payment for each item or service, and
 - Include a notice of the right to an itemized statement

42 CFR §423.128(e)(1),(2)

Subpart C -- Beneficiary Protections

- The written explanation of benefits must also include the total year-to-date amount of benefits provided, in relation to the deductible, the initial coverage limit, and the annual out-of-pocket threshold, and the year-to-date total of incurred costs, “to the extent practicable”

42 CFR §423.128(e)(3),(4)

Subpart C -- Beneficiary Protections

- The written explanation of benefits must also include any applicable formulary changes for which Part D plans are required to provide notice

42 CFR §423.128(e)(5)

Subpart C -- Beneficiary Protections

- The Part D Plan must abide by all applicable federal and state privacy laws
- The Part D Plan must ensure timely access for the enrollee to the records and information that pertain to the enrollee

42 CFR §423.136

Subpart M – Grievances, Coverage Determinations, and Appeals

- A Part D Plan sponsor must have procedures for:
 - Grievances that do not involve coverage determinations
 - Coverage determinations
 - Appeals of coverage determinations

42 CFR §423.562(a)(1)(i),(ii),(iii)

Subpart M – Grievances, Coverage Determinations, and Appeals

- A Part D Plan sponsor must ensure that enrollees receive written information about:
 - The grievance and appeal procedures, and
 - The complaint process available through the Quality Improvement Organization (QIO)

42 CFR §423.562(a)(2)(i),(ii)

Subpart M – Grievances, Coverage Determinations, and Appeals

- A Part D Plan sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees who disagree with the information provided by the pharmacist to contact their plans to:
 - Obtain a coverage determination, or
 - Request an exception

42 CFR §423.562(a)(3)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Grievance procedures are separate and distinct from
 - Appeal procedures (which address coverage determinations)
 - The Quality Improvement Process (QIO)

42 CFR §423.564(b),(c)

Subpart M – Grievances, Coverage Determinations, and Appeals

- As noted, grievance procedures are separate and distinct from the Quality Improvement Process (QIO)
 - For quality of care issues, the enrollee can:
 - File a grievance with PDP sponsor,
 - File a written complaint with the QIO, or
 - Do both

42 CFR §423.564(b),(c)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Grievance procedures apply to:
 - The Part D Plan sponsor, and
 - Any entity or person through whom the Part D Plan sponsor provides covered Part D benefits

42 CFR §423.564(a)

Subpart M – Grievances, Coverage Determinations, and Appeals

- A grievance:
 - May be filed either orally or in writing
 - Must be filed within 60 days after the event or incident that precipitates it

42 CFR §423.564(d)(2), (e)(1),(2)

Subpart M – Grievances, Coverage Determinations, and Appeals

- A grievance must be decided by the Plan sponsor within 30 days
 - If the enrollee so requests, or if the Plan sponsor justifies a need for additional information and it is “in the interest of the enrollee” the Plan sponsor can extend the decision time by up to 14 days

42 CFR §423.564(d)(2), (e)(1),(2)

Subpart M – Grievances, Coverage Determinations, and Appeals

- A grievance:
 - In writing must be responded to in writing
 - Orally filed may be responded to orally or in writing
 - If the enrollee requests a written response, the response must be written

42 CFR §423.564(e)(3)(i),(ii)

Subpart M – Grievances, Coverage Determinations, and Appeals

- A grievance relating to quality of care:
 - Must be responded to in writing regardless of how filed and the response must inform the enrollee of the right to file a complaint with the Quality Improvement Organization

42 CFR §423.564(e)(3)(iii)

Subpart M – Grievances, Coverage Determinations, and Appeals

- A grievance relating to a refusal to grant an expedited coverage determination or expedited redetermination must be responded to within 24 hours if the enrollee has not yet purchased or received the drug in dispute

42 CFR §423.564(f)

Subpart M – Grievances, Coverage Determinations, and Appeals

- The Part D plan sponsor must track and record all grievances, including:
 - Date of receipt,
 - Final disposition, and
 - Date of notification of the disposition

42 CFR §423.564(g)

Subpart M – Grievances, Coverage Determinations, and Appeals

- The Part D plan sponsor must have a procedure for making timely coverage determinations, including:
 - Basic prescription drug coverage
 - Supplemental benefits, and
 - The amount (including cost sharing, if any) that the enrollee must pay for the drug

42 CFR §423.566(a)

Subpart M – Grievances, Coverage Determinations, and Appeals

- The Part D plan sponsor must have a procedure for making:
 - Standard coverage determinations, and
 - Expedited coverage determinations

42 CFR §423.566(a)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Several different types of actions are coverage determinations

42 CFR §423.566(b)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Coverage determinations include:
 - A decision not to provide or pay for a Part D drug

42 CFR §423.566(b)(1)

Subpart M – Grievances, Coverage Determinations, and Appeals

- The decision not to provide or pay for a Part D drug may be due to:
 - The drug is not on the Plan formulary,
 - The drug is not medically necessary,
 - The drug is furnished by an out-of-network pharmacy,
or
 - The Plan sponsor determines that the drug is otherwise excludable

42 CFR §423.566(b)(1)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Coverage determinations include:
 - Failure to provide a coverage determination in timely manner if the delay would adversely affect the health of the enrollee

42 CFR §423.566(b)(2)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Coverage determinations include:
 - A decision concerning an exceptions request to tiered cost-sharing
 - A decision concerning an exceptions request for a non-formulary drug

42 CFR §423.566(b)(3),(4)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Exceptions requests are subject to §423.578:
 - (a) Exceptions requests to tiered cost-sharing may be filed when the enrollee requests a “non-preferred drug” on the terms of a “preferred drug”
 - The prescribing physician must state (orally or in writing) that the preferred drug (1) would not be as effective for the enrollee as the non-preferred drug; or (2) would have adverse effects for the enrollee, or (3) both
 - A Plan sponsor may require oral physician’s support to be followed up in writing

42 CFR §423.578(a)(1-5)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Exceptions requests are subject to §423.578:
 - A Part D plan sponsor is not required to cover a non-preferred drug at the generic cost-sharing level if the plan maintains a separate tier dedicated to generic drugs

42 CFR §423.578(a)(6)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Exceptions requests are subject to §423.578:
 - A Part D plan sponsor that maintains a formulary tier for very high cost and unique items (such as genomic and biotech products) may exempt those items from the tiering exceptions process

42 CFR §423.578(a)(7)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Exceptions requests are subject to §423.578:
 - (b) A Part D plan sponsor must have an exceptions process for off-formulary drugs

42 CFR §423.578(b)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Under the exceptions process for off-formulary drugs, the Plan sponsor must grant an exception and cover an off-formulary drug when it determines that the off-formulary drug is medically necessary

42 CFR §423.578(b)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Under the exceptions process for off-formulary drugs, the prescribing physician must provide an oral or written statement that the off-formulary drug is medically necessary
 - The Plan sponsor can require oral physician information to be followed up in writing

42 CFR §423.578(b)(5),(6)

Subpart M – Grievances, Coverage Determinations, and Appeals

- The decision made by the Plan sponsor under the exceptions process is a coverage determination

42 CFR §423.578(c)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Coverage determinations also include:
 - A decision concerning the amount of cost-sharing

42 CFR §423.566(b)(5)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Coverage determinations can be requested by:
 - The enrollee, or
 - The enrollee’s appointed representative, or
 - The prescribing physician on behalf of the enrollee

42 CFR §423.566(c)(1),(2),(3)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Timeframe for coverage determinations:
 - No later than 72 hours after receipt of the:
 - Request for the drug benefit, or
 - Physician’s supporting statement in the case of an exceptions request, or
 - Request for payment

42 CFR §423.568(b)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Requests for expedited coverage determinations require the Plan sponsor to have procedures for expediting the determination if the standard timeframe may seriously jeopardize the enrollee's:
 - Life, or
 - Health, or
 - Ability to regain maximum function

42 CFR §423.570(c)(3)(i),(ii)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Timeframe for expedited coverage determinations:
 - No later than 24 hours after receipt of the:
 - Request for the drug benefit, or
 - Physician's supporting statement in the case of an exceptions request

42 CFR §423.572(a)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Denial of request for expedited coverage determinations requires the Plan sponsor to:
 - Inform the enrollee of the right to:
 - File an expedited grievance, and
 - Resubmit the request for expediting with the prescribing physician's support,
 - Make the determination within 72 hours, and
 - Provide instructions about the Plan's grievance process and timeframes

42 CFR §423.570(d)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Effect of failure to meet timeframes:
 - The failure to meet the adjudicatory timeframe for either a standard or expedited coverage determination:
 - Amounts to an adverse coverage determination, and
 - Requires the Plan sponsor to forward the request to the Independent Review Entity (IRE)

42 CFR §§423.568(e), 423.572(d)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Notices of coverage determinations (standard or expedited) that are not fully favorable must:
 - State the specific reason for the denial, and
 - Describe both the standard and expedited redetermination process, including the enrollee's right to and conditions for expedited redetermination, and
 - Describe the rest of the appeals process

42 CFR §§423.568(d), 423.572(c)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Effect of a coverage determination:
 - The coverage determination is binding on the Plan sponsor and the enrollee unless it is revised via redetermination or one of the other further appeals steps, or is reopened and revised

42 CFR §423.576(d)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Redetermination may be requested:
 - By the enrollee or on the enrollee's behalf by the prescribing physician, and
 - As a standard redetermination or as an expedited redetermination

42 CFR §423.580

Subpart M – Grievances, Coverage Determinations, and Appeals

- Redetermination may be requested:
 - By making a written request with the Part D plan sponsor that made the coverage determination
 - Within 60 calendar days of the of the date of notice of the coverage determination
 - For good cause, the Part D plan sponsor can extend the 60 day timeframe, even after it has expired

42 CFR §423.582

Subpart M – Grievances, Coverage Determinations, and Appeals

- Expedited redetermination may be requested if the issue is:
 - A decision not to provide or pay for a Part D drug, or
 - Failure to provide a timely coverage determination when the delay would adversely affect the enrollee's health, or
 - An exceptions request, or
 - A decision on the amount of cost-sharing
- Expediting is not available if the drug(s) has/have already been furnished

42 CFR §423.584(a)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Expedited redetermination must be provided if the Plan sponsor determines that applying the standard timeframe may seriously jeopardize the enrollee's:
 - Life, or
 - Health, or
 - Ability to regain maximum function

42 CFR §423.584(c)(2)(i)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Expedited redetermination must be provided if the prescribing physician indicates that applying the standard timeframe may seriously jeopardize the enrollee's:
 - Life, or
 - Health, or
 - Ability to regain maximum function

42 CFR §423.584(c)(2)(ii)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Expedited redetermination, if it occurs, requires notice of the redetermination within 72 hours of receipt of the request

42 CFR §423.590(d)(1)

Subpart M – Grievances, Coverage Determinations, and Appeals

- If the Plan sponsor denies the request for expedited redetermination, it must make the redetermination in the timeframe for a standard redetermination (7 calendar days from the date of receipt of the request)

42 CFR §423.584(d)(1)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Timeframe for a standard redetermination is 7 calendar days from the date of receipt of the request

42 CFR §423.590(b)(1)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Opportunity to submit evidence
 - The Plan D sponsor must provide a reasonable opportunity to present evidence and allegations of fact and law
 - For expedited redeterminations, the Plan sponsor must seek the information within 24 hours of receipt of the request
 - The Plan sponsor must give notice of the conditions for submitting evidence

42 CFR §§423.586, 423.590(d)(2)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Adverse redetermination – form of notice
 - The notice of any adverse redetermination must:
 - Be readable and understandable, and
 - State the specific reasons for the denial, and
 - Inform the enrollee of the right to reconsideration

42 CFR §423.590(g)(1),(2),(3)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Adverse redetermination – form of notice
 - The notice of any adverse redetermination for drug coverage must describe:
 - Both the standard and expedited reconsideration processes and the conditions for obtaining expedited reconsideration, and
 - The rest of the appeals process

42 CFR §423.590(g)(i)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Adverse redetermination – form of notice
 - The notice of any adverse redetermination for payment must describe:
 - The standard reconsideration process, and
 - The rest of the appeals process

42 CFR §423.590(g)(ii)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Reconsideration is:
 - A right of the enrollee, if dissatisfied with redetermination
 - Conducted by an Independent Review Entity (IRE) that contracts with CMS

42 CFR §423.600(a)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Reconsideration:
 - Must be requested within 60 days of the date of the redetermination

42 CFR §423.600(a)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Reconsideration:
 - Requires that the IRE:
 - Solicit the views of the prescribing physician (either orally or in writing), and
 - Put a written account of the prescribing physician's views in the IRE's records

42 CFR §423.600(b)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Reconsideration in regard to non-formulary drugs:
 - Requires that the prescribing physician determine that all covered Part D drugs on any tier of the formulary for treatment of the same condition:
 - Would not be as effective for the individual as the non-formulary drug, or
 - Would have adverse side effects, or
 - Both

42 CFR §423.600(c)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Reconsideration in regard to denial of coverage based on lack of medical necessity:
 - Must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue

42 CFR §423.600(e)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Reconsideration timelines:
 - Are the same as for redeterminations:
 - Standard – 7 days
 - Expedited – 72 hours

42 CFR §423.600(d)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Reconsideration notices must:
 - State the specific reasons for the IRE’s decision “in understandable language”
 - If not wholly favorable, inform the enrollee of the right to an Administrative Law Judge (ALJ) hearing if the amount in controversy is met
 - Describe the procedures to request an ALJ hearing

42 CFR §423.602(b)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Reconsideration notices must be mailed to:
 - The enrollee,
 - The Plan sponsor, and
 - CMS

42 CFR §423.602(a)

Subpart M – Grievances, Coverage Determinations, and Appeals

- Reconsideration decisions are binding on:
 - The enrollee, and
 - The Plan sponsor
- Unless the enrollee requests an ALJ hearing

42 CFR §423.604

Subpart M – Grievances, Coverage Determinations, and Appeals

- Right to an ALJ hearing:
 - If the amount in controversy meets the threshold requirement (established annually) an enrollee dissatisfied with the reconsideration determination can request an ALJ hearing
 - The amount in controversy threshold is currently \$130 (this can increase from year to year)

42 CFR §423.610

Subpart M – Grievances, Coverage Determinations, and Appeals

- Right to an ALJ hearing:
 - Must be exercised within 60 days of the date of notice of the IRE reconsideration redetermination (unless extended by the ALJ)

42 CFR §423.612

Subpart M – Grievances, Coverage Determinations, and Appeals

- Right to review by the Federal district court:
 - Exists if the enrollee is dissatisfied with the decision of the Medicare Appeals Council, and
 - If the amount in controversy threshold is met (presently \$1,350 in 2012, this can increase annually), and
 - Must be exercised within 60 days of the date of notice of the Medicare Appeals Council decision

42 CFR §423.630

Subpart M – Grievances, Coverage Determinations, and Appeals

- Right to review by Federal district court:
 - Will be “on the record” – no new evidence will be accepted (last best chance to get evidence in is at the ALJ stage)
 - Decision is subject to further appeal as is any Federal district court decision

42 CFR §423.630

Subpart M – Grievances, Coverage Determinations, and Appeals

- Reopening and revising determinations and decisions
 - Can be requested by the enrollee
 - If it occurs,
 - It will be done by the entity that made the decision
 - Revisions themselves can be appealed

42 CFR §423.634

Low-Income Subsidy

- Social Security was assigned the duty of processing applications for the low-income subsidy
- Social Security's rules for the low-income subsidy process are at 20 CFR Part 418

20 CFR §§418.3001 *et seq.*

Low-Income Subsidy

- Unless an individual is *deemed eligible* for the low-income subsidy, the individual must apply for the subsidy
 - *Deemed eligibles* include Medicare beneficiaries in nursing homes who also receive Medicaid, Medicare beneficiaries who are SSI recipients, Medicare Savings Programs beneficiaries, and Medicare beneficiaries with income at or below 100% of FPIL

20 CFR §418.3105; 42 CFR §423.773(c)

Low-Income Subsidy

- The application may be filed:
 - Using an application form developed by Social Security; or
 - Online at www.socialsecurity.gov; or
 - By phone (in which case the Social Security worker will complete the application at a computer screen)

20 CFR §418.3210

Low-Income Subsidy

- If an individual applies and meets the requirements for subsidy, Social Security notifies the individual in writing
- The notice has four parts

20 CFR §418.3110

Low-Income Subsidy

- The Social Security notice states:
 - (1) Whether the subsidy will be full or partial, and that eligibility for it will last for one year;
 - (2) The information used and how income and resources were calculated;
 - (3) What to do if circumstances change; and
 - (4) Appeal rights

20 CFR §418.3110(b)

Low-Income Subsidy

- An individual determined by Social Security to be not eligible for any subsidy (full or partial):
 - Will be notified of the reason(s) for ineligibility, including how income and resources were calculated; and
 - Will be informed that the individual can reapply if circumstances change; and
 - Will be informed of appeal rights

20 CFR §418.3110(c)

Low-Income Subsidy

- Changed circumstances may affect eligibility for any subsidy (full or partial):
 - Marriage, divorce, annulment, separation (other than temporary), death of a spouse who was living with the individual
 - Any of the above events will lead Social Security to send a redetermination form, which must be returned within 90 days

20 CFR §418.3120(a)(1-5),(b)(1)

Low-Income Subsidy

- Subsidy eligibility may also change due to:
 - Changes in income (excluding cost-of-living adjustments for public benefits), resources, household composition (other than those listed above), new eligibility for regular Medicaid, long-term care Medicaid, or a Medicare Savings Program
 - Any of the above events will lead Social Security to send a redetermination form between August and December, which must be returned within 30 days

20 CFR §418.3120(b)(2)

Low-Income Subsidy

- If Social Security increases, decreases, or terminates the subsidy, the individual receives a written notice

20 CFR §418.3120(b)(3)

Low-Income Subsidy

- The written notice states:
 - Whether the individual can receive a full or partial subsidy;
 - How Social Security calculated income and resources;
 - When the change in subsidy is effective

20 CFR §418.3120(b)(3)

Low-Income Subsidy

- The written notice also states:
 - The individual's appeal rights, and
 - What the individual should do if the individual's circumstances change

20 CFR §418.3120(b)(3)

Low-Income Subsidy

- If the individual becomes eligible for regular Medicaid, long-term care Medicaid, or a Medicare Savings Program, CMS issues notice of any change in the subsidy

20 CFR §418.3120(c)

Low-Income Subsidy

- Changes due to marriage, divorce, annulment, separation (other than temporary), or death of a spouse with whom the individual was living are effective the month following the month of the report from the individual

20 CFR §418.3123(a)

Low-Income Subsidy

- Changes due to changes in income, resources, or family composition (other than those listed above) are effective in January of the following year

20 CFR §418.3123(b)

Low-Income Subsidy

- If the report form due in 90 days in regard to marriage, divorce, annulment, separation (other than temporary), or death of the spouse (with whom the individual was living) is not returned, subsidy terminates the month following the end of the 90 days

20 CFR §418.3123(c)

Low-Income Subsidy – Redetermination by Social Security

- Social Security will redetermine eligibility for subsidy within one year for individuals for whom it made the initial eligibility determination, and SSI recipients

20 CFR §418.3125(b)(1)

Low-Income Subsidy – Redetermination by Social Security

- Social Security's periodic redetermination is prospective – it does not affect past subsidy

20 CFR §418.3125(a)

Low-Income Subsidy – Redetermination by Social Security

- After Social Security's first periodic redetermination (within the first year) further periodic redeterminations will occur at periods based on likelihood of changes in circumstances and changes in level of subsidy

20 CFR §418.3125(b)(2)

Low-Income Subsidy – Redetermination by Social Security

- Social Security may also redetermine eligibility for and level of subsidy upon receipt of information from the individual or from “data exchanges”

20 CFR §418.3125(b)(3)(4)

Low-Income Subsidy – Redetermination by Social Security

- Social Security will also redetermine eligibility for and level of subsidy on a random sample basis, and will contact third parties for information (such as wage information)

20 CFR §418.3125(b)(5)

Low-Income Subsidy – Income and Resource Criteria

- Social Security uses income and resource exclusions similar to SSI in determining eligibility for and level of subsidy.

20 CFR §§418.3301, 418.3401

Low-Income Subsidy – Administrative Review

- There is a right to administrative review of:
 - Social Security's
 - Initial determination regarding
 - Eligibility for and level of subsidy; or
 - Continuation of or change to eligibility for subsidy and level of subsidy

20 CFR §418.3601

Low-Income Subsidy – Administrative Review

- Initial determinations include:
 - Calculation of income and/or resources;
 - Eligibility for subsidy and level of subsidy;
 - Reductions of subsidy;
 - Termination of subsidy

20 CFR §418.3605

Low-Income Subsidy – Administrative Review

- Social Security will mail written notice of the initial determination to the individual
 - The notice will state appeal rights

20 CFR §418.3615

Low-Income Subsidy – Administrative Review

- Social Security’s notice will inform the individual of the right to continue receiving the previously established subsidy until the administrative review is decided
 - There is no requirement to pay back subsidy received while the review is pending

20 CFR §§418.3615(c), 418.3510

Low-Income Subsidy – Administrative Review

- Social Security’s initial determination is binding unless administrative review is requested within 60 days of the date of receipt of the notice of initial determination
 - For “good cause” the time period can be extended

20 CFR §§418.3620(c), 418.3630

Low-Income Subsidy – Administrative Review

- The request for administrative review can be made to any Social Security office
- The request can be made by mail, phone, or fax

20 CFR §418.3630

Low-Income Subsidy – Administrative Review

- Administrative review will be by telephone, unless the individual chooses a “case review”
 - A case review is based on the information in the file and additional information the individual provides
- The notice of the setting of the administrative review by telephone will be sent at least 20 days before the hearing

20 CFR §418.3625

Low-Income Subsidy – Administrative Review

- The notice of administrative review will state the specific specific issues to be decided
- If the individual objects to the person who will conduct the administrative review, Social Security must be notified as soon as possible
 - Social Security decides whether a different person will conduct the review

20 CFR §§418.3625(a), 418.3645

Low-Income Subsidy – Administrative Review

- A notice of administrative review by telephone will state the procedure for:
 - Reviewing the file
 - Submitting additional evidence
 - Subpoenaing witnesses and documents
 - Requesting a change of date or time

20 CFR §418.3625 (a)

Low-Income Subsidy – Administrative Review

- A notice of administrative review by telephone will also state the procedure for requesting interpreter services
- The notice will also explain the procedures of a telephone hearing

20 CFR §418.3625 (a)

Low-Income Subsidy – Administrative Review

- If the individual does not participate in the scheduled telephone hearing, the review will be a case review
- If there was “good cause” for missing the telephone hearing, the individual can ask that it be rescheduled

20 CFR §418.3625 (a)

Low-Income Subsidy – Administrative Review

- The individual can be represented by a “personal representative” of the individual’s choosing
 - If the individual is incapacitated or incompetent, the personal representative can be someone acting on behalf of the individual

20 CFR §418.3635, incorporating 20 CFR §423.772

Low-Income Subsidy – Administrative Review

- Written notice of the decision will be sent to the individual's last known address
- If the subsidy is stopping because of the death of the individual, notice “generally will not be sent”

20 CFR §418.3655

Low-Income Subsidy – Administrative Review

- The written notice of the decision will state:
 - What the decision is
 - The reasons for the decision
 - The effect of the decision
 - The right to judicial review of the decision

20 CFR §418.3655

Low-Income Subsidy – Administrative Review

- The right to Federal court judicial review must be exercised within 60 days after receipt of the decision on administrative review
 - If this deadline is missed, for good cause shown, Social Security can extend it

20 CFR §418.3675

Low-Income Subsidy – Administrative Review

- If Federal court judicial review results in an order remanding the case to Social Security, the usual administrative review procedures will be used, unless Social Security decides to rule entirely in favor of the individual

20 CFR §418.3680

Low-Income Subsidy – Use of State Medicaid agency

- If an individual applies for subsidy with the state Medicaid agency, the same appeal procedures as used in the state Medicaid program are to be used
- Texas now has state court judicial review of state Medicaid appeal decisions

42 CFR §423.774, Texas Government Code §2001.223(1)

Help is available as you help clients

- If you are a Benefits Counselor of a Texas Area Agency on Aging and you are assisting a client with Medicare Part D matter and want the back-up and support of the Legal Hotline for Texans, the assistance of Hotline attorney is yours for the asking.