DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid
Services 7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEMORANDUM

DATE: February 17, 2017

TO: All Part D Sponsors

SUBJECT: Best Available Evidence Process Update

FROM: Amy Larrick Chavez-Valdez, Director
Medicare Drug Benefit and C & D Data Group

Part D Sponsors (Sponsors) are required to administer reduced cost sharing for low-income subsidy (LIS) eligible individuals. The best available evidence (BAE) process enables Sponsors to meet this requirement even when the Centers for Medicare & Medicaid Services (CMS) systems do not reflect a beneficiary's correct LIS status at a particular point in time. In such cases the sponsor will submit a "beneficiary assistance request" to confirm a beneficiary's LIS eligibility to CMS.

The purpose of this memorandum is to introduce a new automated process which allows Sponsors to submit real-time beneficiary assistance requests through the Health Plan Management System's Complaints Tracking Module (CTM). Sponsors are encouraged to use this approach when the updated CTM module is released in March 2017. Sponsors may, however, continue to use the current submission process until May 31, 2017.

New Process for Assisting Individuals without BAE Documentation

The new automated system for submitting BAE documentation through CTM will work as follows:

1. Recording of a case in the CTM (Plan Responsibility). Plans are to enter cases in the CMS Lead category and the "Premiums and Costs - Beneficiary needs assistance with acquiring Medicaid eligibility information (EX)" subcategory for CMS review/action. These cases will be reflected as "1.50" in the plan data extract and are excluded from CMS' plan complaint performance metrics. Absent unusual circumstances, cases are to be entered by Sponsors within one business day of being notified that the beneficiary claims to be subsidy eligible but cannot provide the sponsor with acceptable BAE evidence. When entering a case, include all of the following:

    - Health Insurance Claim Number (HICN) or Medicare Beneficiary

Identifier (MBI)
- Beneficiary's First and Last Name
- Beneficiary's Address
- Beneficiary's Date of Birth
- Issue Level. If the beneficiary has less than 3 days of medication remaining, select "Immediate Need." If the beneficiary has 3-14 days of medication remaining, select "Urgent." For all other situations, select "No Issue Level"
- Any additional information germane to the beneficiary's matter.

2. Determining the Results of the Request (CMS Responsibility). After receiving the CTM case, CMS will attempt to confirm with the appropriate state Medicaid agency whether the beneficiary is eligible for LIS. Upon CMS review and action, the case will be moved to Plan Lead category and the "Premiums and Costs- Beneficiary needs assistance with acquiring Medicaid eligibility information (EX)" subcategory for plan review/action. These cases will be reflected as "2.50" in the plan data extract. Additional information will be placed in the Comments section of the case and will include as applicable:

   - Resolution
   - Start of Medicaid/ Medicaid Institutional Status (MM/CCYY)
   - Dual Eligible Status (Full/Partial)
   - Institutional Status (Yes/No/ Unknown)
   - LIS Co-Pay Level
   - Any additional information germane to the beneficiary's matter.

3. Implementing Outcome (Plan Responsibility). After CMS has concluded its review, the sponsor will update its internal systems to reflect LIS status if appropriate and submit a request for correction to CMS' contractor in accordance with the procedures outlined in section 70.5.4 of the CMS Prescription Drug Benefit Manual, Chapter 13. If CMS determines the beneficiary ineligible for LIS, no system updates are to be initiated. Consistent with the direction in section 70.5.3 of the CMS Prescription Drug Benefit Manual, Chapter 13, Sponsors are to:

   - Attempt to notify the beneficiary of the results of the CMS review within one business day of receiving those results. If a sponsor is unable to reach the beneficiary as a result of this initial attempt, it must attempt to notify the beneficiary until it succeeds or until it has attempted to do so a total of four times. The fourth attempt, if necessary, shall be in writing, using one of two CMS Model Notices listed in Chapter 13 of the CMS Prescription Drug Benefit Manual.

   - If CMS determines that the beneficiary *is* LIS eligible, Sponsors are to send the "Determination of LIS Eligibility" Model Notice provided here as Attachment A. If CMS determines that the beneficiary *is not* LIS eligible, or is unable to confirm the beneficiary's LIS status, Sponsors are to use the "Determination of LIS Ineligibility" Model Notice provided here as Attachment B.

- If a request for a subsidy was made on the beneficiary's behalf by an advocate or authorized representative, it shall be sufficient for the sponsor to contact that advocate or representative. If, however, the only request made on the beneficiary's behalf was by a pharmacist, the sponsor must also contact the beneficiary directly. After informing the beneficiary, or their representative of the outcome, the sponsor is to close the case.

- Should the beneficiary disagree with the outcome, the sponsor is to use the "Plan Request" feature in CTM to refer the matter back to CMS with appropriate notes. A CMS caseworker will attempt to contact the beneficiary, affirm the outcome, and close the case.

In rare circumstances, a beneficiary's record may be incorrect in CMS systems after they have applied for and been awarded the Part D extra help through the Social Security Administration. In these instances, make certain the beneficiary is able to access their Part D plan benefit. Sponsors may use this new CTM process to advise to CMS when our systems need to be updated since corrections cannot be submitted to the Retro Processing Contractor (RPC) for processing.

As soon as the Sponsor receives confirmation from CMS that a beneficiary is subsidy eligible, the Sponsor must provide the beneficiary access to covered Part D drugs at a reduced cost-sharing level no greater than the higher of the LIS cost-sharing levels for full subsidy eligibles, or at zero cost- sharing if CMS also verifies the beneficiary's institutional status. This process is not intended to serve as a general alternative to the subsidy eligibility confirmation process. Thus, it does not permit pharmacies or any other parties to send beneficiary records directly to the Sponsor for research in the absence of a request for assistance from the beneficiary (or other individual on the beneficiary's behalf) or in lieu of making reasonable efforts to acquire the documentation from, or on behalf of, the beneficiary.

Please refer to Chapter 13 of the Prescription Drug Benefit Manual[1], for more information about BAE policies. For questions concerning the BAE policy, please contact PartD_COB@cms.hhs.gov, with a copy your Account Manager. For questions about the new CTM procedure, please contact CTMRedesign@cms.hhs.gov, with a copy to your Account Manager.

[1] Accessible at https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/chapter13.pdf

Attachment A – CMS Model Notice "Determination of LIS Eligibility"
Plans should submit this notice as File & Use in HPMS under category 7000-Special Materials, code 7003-CMS Mandated Notices. This letter is unchanged from the August 2008 HPMS memorandum.

[Member#-if member # is SSN, only use last 4 digits] [RxID]
[RxGroup]
[RxBin] [RxPCN

<Date>

Dear <Name of Member>:

On <Date>, you asked <Plan name> for help showing you qualify for extra help with your Medicare prescription drug costs. Medicare contacted your State Medicaid Agency and confirmed that **you do qualify for extra help**.

Since you qualify for extra help, your Medicare prescription drug costs will be reduced. You will get more information from us shortly on the specific amounts you will pay for your premiums and prescriptions in our plan.

If you have any questions, please call our Member Services at <phone number><days and hours of operation>. TTY users should call <TTY number>.

<Material ID>

Attachment B – CMS Model Notice "Determination of LIS Ineligibility"
Plans should submit this notice as File & Use in HPMS under category 7000-Special Materials, code 7003-CMS Mandated Notice. This letter is unchanged from the August 2008 HPMS memorandum.

[Member#-if member # is SSN, only use last 4 digits]
[RxID]
[RxGroup]
[RxBin]
[RxPCN

<Date>

Dear <Name of Member>:

On <Date>, you asked <Plan name> for help showing that you qualify for extra help with your Medicare prescription drug costs.

Medicare contacted your State Medicaid Agency and <insert either "confirmed that **you do not automatically qualify for extra help**" or "**has not been able to confirm that you automatically qualify for extra help**">.

<If Medicare confirmed that the individual is <u>not</u> automatically eligible for LIS, insert the following paragraph:

> "You may still qualify for extra help, but you must apply to find out. If you haven't already filled out an application for extra help, you can get an application or apply over the phone by calling Social Security at 1-800-772-1213, or apply online at www.socialsecurity.gov on the web. TTY users should call 1-800-325-0778. If you have any questions, please call our Member Services at <phone number><days and hours of operation>. TTY users should call <TTY number>."

If you have any questions or you believe this information is wrong, please call<Regional Contact> at <phone number> in the regional office of the Centers for Medicare and Medicaid Services.

<Material ID>