70.5 - Best Available Evidence (BAE)
(Rev. 7, Issued: 11-21-08; Effective/Implementation: 11-21-08)

When situations arise that result in incorrect LIS cost-sharing data at the point-of-sale, Part D sponsors must comply with the "Best Available Evidence" (BAE) policy. This policy requires sponsors to update their systems to reflect the appropriate cost-sharing subsidy for Part D eligible individuals who are full benefit Medicare/ Medicaid dual eligible individuals, MSP, and receiving SSI-only when presented with evidence that information showing the beneficiary to be ineligible is not correct. This section outlines the requirements Part D sponsors must follow when applying the BAE policy to its members.

70.5.1- BAE Policy Communication and Oversight
(Rev. *8*, Issued: *10-01-18*; Effective/Implementation: *10-01-18*)

Part D sponsors must develop appropriate member services and pharmacy help desk scripting to identify cases involving a situation in which the BAE policy applies, and to allow callers either to submit BAE pursuant to the requirements described in section 70.5.2 or to request assistance pursuant to the requirements described in section 70.5.3.

Sponsors must also provide a link on their Web site to the section of CMS' Web site regarding BAE policy and make information about the BAE policy readily available for those who contact the plan's call center. The Web site address is:

https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/best_available_evidence_policy.html

Given the importance of this policy to low-income beneficiaries, CMS *tracks BAE issues in the Complaints Tracking Module* and closely monitors Part D sponsor compliance with this policy.

70.5.2 - Required Documentation and Verification
(Rev. *14*, Issued: *10-01-18*, Effective Date: *10-01-18*; Implementation Date: *10-01-18*)

Part D sponsors are required to accept any of the following forms of evidence to establish the subsidy status of a full benefit dual eligible or MSP-eligible beneficiary when provided by the beneficiary or the beneficiary's pharmacist, advocate, representative, family member or other individual acting on behalf of the beneficiary. Sponsors must include a copy of one of the following BAE documents with every update request submitted to CMS' contractor (see section 70.5.4):

a. A copy of the beneficiary's Medicaid card that includes the beneficiary's name and an eligibility date during a month after June of the previous calendar year;
b. A copy of a state document that confirms active Medicaid status during a month after June of the previous calendar year;
c. A print out from the State electronic enrollment file showing Medicaid status during a month after June of the previous calendar year;
d. A screen print from the State's Medicaid systems showing Medicaid status during a month after June of the previous calendar year;
e. Other documentation provided by the State showing Medicaid status during a month after June of the previous calendar year;
f. A letter from SSA showing that the individual receives SSI; or,

g. An Application Filed by Deemed Eligible confirming that the beneficiary is "…automatically eligible for extra help…" (SSA publication HI 03094.605)

Part D sponsors are required to accept any one of the following forms of evidence from the beneficiary or the beneficiary's pharmacist, advocate, representative, family member or other individual acting on behalf of the beneficiary to establish that a beneficiary is institutionalized or, beginning on a date specified by the Secretary, but no earlier than January 1, 2012, is an individual receiving home and community based services (HCBS) and qualifies for zero cost- sharing:

a. Remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year;

b. Copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year;

c. Screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year.

d. Effective as of a date specified by the Secretary, but no earlier than *January 1, 2017,* a copy of**:**

1. State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary's name and HCBS eligibility date during a month after June of the previous calendar year;

2. State-approved HCBS Service Plan that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;

3. State-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;

4. Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year; or,

5. State-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS.

The sponsor may also prepare a report of contact as evidence of a beneficiary's status as a full benefit dual eligible individual, institutionalized individual, and/or HCBS recipient when the sponsor makes a verification call to the State Medicaid Agency. The report of contact must include the date of the verification call and the name, title and telephone number of the state staff person who verified the Medicaid status during a month after June of the previous calendar year.

The documents listed above are valid for the purpose of establishing the correct LIS cost-sharing level and effective date for individuals who should be deemed eligible for LIS, and are the only documents permissible for submission to CMS' contractor for deeming updates.

- As soon as one of the forms of BAE listed above is presented, provide the beneficiary access to covered Part D drugs at a reduced cost-sharing level which is no greater than the higher of the LIS cost-sharing levels for full subsidy eligible individuals*, (See applicable calendar year copayment amounts provided in the Annual Call Letter)*, or at zero cost-sharing if the BAE also verifies the beneficiary's institutional status.

- Update sponsor systems to reflect the correct LIS status based upon BAE documentation, override the standard cost-sharing, and maintain an exceptions process for the beneficiary to obviate the need to require the re-submission of documentation each month pending the correction of the beneficiary's LIS status in CMS systems. Part D sponsors will be required to update their systems within 48-72 hours of their receipt of BAE documentation. The requirement that Part D sponsors update their systems within 48-72 hours is in addition to the requirement that Part D sponsors provide access to covered Part D drugs as soon as BAE is presented to them.

- Verify that CMS' systems do not already reflect the beneficiary's correct LIS status. If CMS' systems do not already reflect the updated information for "deemed" beneficiaries, the sponsor must submit a request for correction in accordance with the manual LIS status correction process discussed later in this section.

- *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. You may use the CTM to advise CMS when our systems need to be updated.*

70.5.3 - Part D Sponsors Responsibility When BAE is Not Available (Rev. *14*, Issued: *10-01-18*, Effective Date: *10-01-18*; Implementation Date: *10-01-18*)

Part D sponsors must respond to requests for assistance in securing BAE from a beneficiary or a beneficiary's pharmacist, advocate, family member or other individual acting directly or on behalf of the beneficiary in accordance with the following process outlined below. Note that this process is not intended to serve as a general alternative to the subsidy eligibility confirmation process. Thus, it does not permit pharmacy organizations or any other parties to send beneficiary records directly to the Part D 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.

Sponsors submit BAE assistance requests to CMS through the Health Plan Management System Complaints Tracking Module (CTM) capabilities.
Part D sponsors are required to take the following actions:

Process for Assisting Individuals without BAE Documentation

To provide expedited service on behalf of Medicare beneficiaries, Part D sponsors are to enter BAE assistance requests into the CTM on behalf of their enrollees. The direct CTM recording capability works as follows:

1. *Recording of a case in the CTM (Plan Responsibility). Plans are to enter cases in the CMS Lead category and the "Premium 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 within 48 – 72 hours 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 this manual. If CMS determines the beneficiary ineligible for LIS, no system updates are to be initiated. 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 this Chapter.*

- *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" notice provided as Appendix D.*

- *If a request for a subsidy was made on the beneficiary's behalf by anadvocate 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.*

- ***If CMS determines that the beneficiary is LIS eligible, Sponsors are to send the notice provided as Appendix E.***

- *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. If the CTM case is already closed, the sponsor is to advise the beneficiary to contact CMS at the telephone number listed on their "Determination of LIS Ineligibility" letter (Appendix D).*

When 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 or if the beneficiary is receiving home and community-based services. 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.

70.5.4 - Transmitting and Timing of Manual LIS Status Correction (Rev. *10*, Issued: *10-01-18*, Effective/Implementation Date: *10-01-18*)

Part D sponsors should provide data to CMS' contractor when BAE is confirmed for an individual who should be deemed, or deemed at a more advantageous copayment level or earlier effective date. This process is called the manual LIS status correction process. It is not intended to supplant State MMA data files, in which States report their dual eligible beneficiaries to CMS. It is important to note that a manual update will not be necessary in all BAE cases, as updated information on a subsequent State MMA file may automatically correct the data in CMS systems.

Prior to submitting a manual correction request, Part D sponsors should allow a reasonable time for updated information to be automatically entered into the CMS systems and reported to the plan. CMS recommends that the delay be a minimum of 30 and a maximum of 60 days, as it is likely that a significant portion of those who qualify under BAE policy in one (1) month will be deemed for LIS via the normal process within the next several weeks.

Part D sponsors should verify that CMS's systems do not already reflect the beneficiary's correct status prior to submitting a request for correction. Verification may be accomplished by checking the most recent LIS History Report from CMS or via the Marx Common User Interface.

Prior to submitting the request, Part D sponsors should ensure that all beneficiary identifying information, such as name, date of birth, HICN or *Medicare Beneficiary Identification (MBI) number* is correct.

70.5.5 - Evidence Retention Requirements (Rev. 8, Issued: 11-21-08; Effective/Implementation: 11-21-08)

To accommodate periodic Government audits, Part D sponsors must maintain for 10 years the original documentation used to substantiate the request for manually updating the CMS system.

An alternative to the Part D sponsor maintaining the BAE documentation would be for the Part D sponsor to delegate this activity to trusted business partners, such as a long-term care pharmacy provider. The partners must be contractually obligated to secure BAE, attest to the beneficiary's LIS status, and retain the documentation until requested by the Part D sponsor to support an audit. Since the risk associated with the delegation would be with the Part D sponsor, the business partner could be required to indemnify the Part D sponsor for the incorrect cost-sharing amount if the partner was unable to produce the required documentation when requested by the Part D sponsor.

70.5.6- CMS/SSA Documentation Supporting a Beneficiary's LIS Cost Sharing Level (Rev. 14, Issued: *10-01-18*, Effective Date: *10-01-18*; Implementation Date: