

## Getting to Know: Part D Best Available Evidence (BAE) Policy

The Centers for Medicare & Medicaid Services (CMS) created the Best Available Evidence (BAE) policy to address incorrect Low-Income Subsidy (LIS)/Extra Help (listed as LIS from this point forward) cost sharing data in the electronic data systems of CMS, pharmacy real-time claims systems, and Part D plans. BAE ensures Medicare beneficiaries with LIS aren't charged too much or have higher copayments than expected.

### Why is the LIS copayment amount wrong?

These are common reasons a beneficiary approved for LIS may be charged the wrong copayment or coinsurance amount:

1. States send monthly reports to CMS which contain a person's Medicaid status for those automatically "deemed eligible" for LIS. CMS updates its data system and then updates Part D plans letting them know about any status changes of their members. Sometimes, these messages are miscommunicated.
2. A person approved for LIS but not enrolled in a Part D drug plan will be asked to pay the full cost of the prescriptions at the pharmacy. However, if the beneficiary provides BAE, then the pharmacy can instantly enroll the beneficiary in a temporary Part D insurance at the pharmacy counter called [Low-Income Newly Eligible Transition \(LINET\) Program](#). Humana currently administers the CMS contract for LINET and must follow the BAE policy. See the [CMS/Humana brochure](#) for more detail.

### What is considered Best Available Evidence?

The type of proof that is acceptable **depends on how the beneficiary became eligible for LIS** (i.e., whether they were "deemed eligible" or if they applied for LIS) and upon where they live:

**"Full Duals" Living in a Long-term Care (LTC) Facility:** Beneficiaries with Medicare and Medicaid (known as full duals) that live in a LTC facility are deemed eligible (automatically eligible) for LIS. They pay no copayments for plan-covered drugs. The beneficiary, or anyone acting on their behalf, can present the LTC facility's pharmacy one of the following forms of evidence to show proof of their LIS status:

- A billing remittance from the LTC facility showing Medicaid payment for a full calendar month for the beneficiary during a month after June (Jul.-Dec.) of the previous calendar year;

- A copy of a state document that confirms Medicaid payment on behalf of the beneficiary to the LTC facility for a full calendar month after June (Jul.-Dec.) of the previous calendar year; or
- A screen print from the state’s Medicaid systems showing the beneficiary’s institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June (Jul.-Dec.) during the previous calendar year.

**“Full Duals” with HCBS:** Beneficiaries with Medicaid home and community-based services (HCBS) are deemed eligible for LIS and have no copayments. The beneficiary, or anyone acting on their behalf, can present the pharmacy one of the following forms of evidence to show proof of their LIS status:

- A copy of a 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 (Jul.-Dec.) of the previous calendar year;
- A copy of a state-approved HCBS service plan that includes the beneficiary’s name and effective date beginning during a month after June (Jul.-Dec.) of the previous calendar year;
- A copy of a state-issued prior authorization approval letter for HCBS that includes the beneficiary’s name and effective date beginning during a month after June (Jul.-Dec.) of the previous calendar year;
- Other documentation provided by the state showing HCBS eligibility status during a month after June (Jul.-Dec.) of the previous calendar year; or
- A state-issued document (e.g., remittance advice) confirming payment for HCBS, including the beneficiary’s name and the dates of HCBS.

**Others Dually Entitled Who Have Medicare and Community Medicaid:**

Beneficiaries with Medicare and Medicaid, including those enrolled in a Medicare Savings Program or who get SSI, are deemed eligible for LIS. The beneficiary or anyone acting on their behalf can present their pharmacy one of the following forms of evidence to show proof of their LIS status:

- A Medicaid card (or copy) that shows their name and an eligibility date during a month after June (July-December) of the previous calendar year;
- A screen print or other state document from the state Medicaid’s system that shows active Medicaid status a month after June (July-December) of the previous calendar year;
- A letter from SSA that shows your client receives SSI;

- An “Application Filed by Deemed Eligible” notice from Social Security confirming automatic eligibility for Extra Help based on SSI; or
- Other documentation from the state that shows active Medicaid status a month after June (Jul.-Dec.) of the previous calendar year.

**All Others Who *Applied for LIS*:** Beneficiaries, or anyone acting on their behalf, approved for LIS can present their LIS award letter from Social Security as evidence of their LIS status. LIS letters may include a Notice of Award, Notice of Change, Notice of Planned Action, or Notice of Important Information must be accepted if dated within the past 15 months.

### **How long will the beneficiary wait for the system to update?**

When BAE is given to the pharmacy, the pharmacy transmits it to the Part D plan, which must then update their system to reflect the correct subsidy status within 48-72 hours of receipt. Once verified, plan sponsors must override the standard cost-sharing and maintain an exceptions process for the beneficiary to prevent the need to require re-submission of documentation each month pending the correction of the beneficiary’s LIS status in the CMS system. If CMS’s system does not reflect this update within 30-60 days, then the drug plan must notify CMS by submitting a correction request.

**Important note: LINET Overrides:** The exceptions process to prevent the need for re-submission does not work in LINET. An override per prescription is required by Humana. If a beneficiary needs three medications, then they need three overrides. If the beneficiary needs another prescription the following day, then they’ll need a separate override.

### **What if the beneficiary doesn’t have any of the BAE documents?**

If one of the acceptable proofs of evidence is not available, then the beneficiary or their representative should contact the plan. Plan call centers are required to do the following:

1. Download a “BAE Assistance worksheet” from the CMS [BAE webpage](#).
2. Ask the beneficiary or their representative how soon he/she will run out of medication and indicate whether the request is an immediate need (less than 3 days of medication remaining).
3. Send the worksheet to the CMS Regional Office (RO) Part D contact where the beneficiary lives within 1 business day. The [CMS RO](#) records the complaint in the CMS Complaint Tracking Module (CTM) and then contacts the state Medicaid agency to confirm the beneficiary’s eligibility. The CMS RO returns the completed worksheet to the plan.

4. The plan updates its systems to reflect the LIS status and submits a correction request to the CMS contractor.
5. The plan must then notify the beneficiary of the results within 1 day of receiving the results from the CMS RO. The plan must attempt to contact the beneficiary up to four times regarding the results. The fourth attempt must be in writing to the beneficiary or their representative.
6. If the LIS status is confirmed, the plan must provide the Part D covered drugs at the reduced cost sharing level. In 2025, copayments will be no higher than \$4.90 for generic/\$12.15 for brand-name drugs for those getting full help, or \$0 if your client is determined as having Medicaid institutional or HCBS status.

#### **Other related items**

- What is LINET?

The Limited Income Newly Eligible Transition Program (LINET) is point-of-sale enrollment, temporary (up to 6 months) Part D coverage for persons eligible for LIS but not enrolled in Part D. LINET is particularly helpful for people awarded LIS after the first of the month and would otherwise have to wait a month to enroll in Part D.

- Refund of Overpaid Premiums

Part D plans must make adjustments and issue refunds or recovery notices within 45 days of receiving information regarding a beneficiary's LIS award. If a beneficiary received help paying their Part D premium from other sources, like a State Pharmaceutical Assistance Program (SPAP), then they may not be eligible for reimbursement.

- Refund of Prescription Copayments

Beneficiaries that paid for prescriptions during their LINET covered timeframe (sometimes retroactive) can be reimbursed so long as the prescription is a Medicare covered drug. Beneficiaries must submit a coverage determination request in writing to receive reimbursement from LINET. Beneficiaries will need to submit receipts or other documentation of the amounts paid per prescription.

## References

See the Centers for Medicare & Medicaid Services (CMS) April 1, 2019 [2020 Final Call Letter](#) issued to all plans, which explains the 2017 Part D standard cost-sharing amounts (see page 68), including copayments for the low-income subsidy (LIS) program.

See the Centers for Medicare & Medicaid Services (CMS) [Best Available Evidence webpage](#), which includes the most current BAE plan contact list as well as past Memorandums and reminder notices from CMS to all plans.

See the Centers for Medicare & Medicaid Services (CMS) Prescription Drug Benefit Manual, [Chapter 13](#) – Premium and Cost Sharing Subsidies for Low-Income Individuals, including Section, *60.2 Full Benefit Dual Eligible Individuals Who are Institutionalized or Receiving Home and Community Based Services (HCBS)*, Section *60.2.2, Individuals Receiving HCBS*, and Section *70.5 – Best Available Evidence* for guidance about the BAE and BAE documentation plan sponsors must accept.

See the [Humana Medicare Limited Income Newly Eligible Transition webpage](#) for tip sheets, frequently asked questions and pharmacy tools.