DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-16-16
Baltimore, Maryland 21244-1850


Center for Beneficiary Choices

MEMORANDUM

DATE: June 27, 2007

TO: All Part D Sponsoring Organizations

FROM: Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit Group
Anthony Culotta, Director, Medicare Enrollment and Appeals Group

RE: Part D Guidance – Low-Income Subsidy (LIS) Status Corrections Based on Best Available Evidence

This document provides guidance to Part D plan sponsors on the policies and procedures for initiating corrections to CMS' low-income subsidy data for plan enrollees for whom the plan has documentation— "best available evidence" (BAE)—about their Medicaid eligibility or residence in an institution under a Medicaid-covered stay. We are providing this guidance in advance of the implementation training, which will take place in the July 11, 2007 User Group Call. Plans should review the guidance and submit any questions by July 6, 2007. Plans are asked to ensure that appropriate business and system staff who are responsible for implementing this policy attend the call.

If you have any questions on this guidance, please contact Deborah Larwood via email at Deborah.Larwood@cms.hhs.gov or by phone at 410-786-9500, or Jill Gotts at Jill.Gotts@cms.hhs.gov or 410-786-7794.

# Part D Plan Sponsor Guidance — LIS Status Corrections Based on Best Available Evidence

**Part D Plan Sponsor Guidance on LIS Corrections**

**Based on Best Available Evidence**

Table of Contents

## Background on Low-Income Subsidy Deeming

The low-income subsidy is extra help for people with Medicare who have limited income and resources to help pay their Medicare prescription drug plan costs (plan monthly premiums, co-payments and the annual deductible). Certain groups of Medicare beneficiaries are automatically deemed eligible for LIS. These groups include full-benefit dual eligible individuals, partial dual eligible individuals (i.e., those who belong to a Medicare Savings Program as a Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary or Qualifying Individual), 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 a low-income subsidy and have their eligibility determined by either the Social Security Administration (SSA) or their State Medicaid Agency. Table 1 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<br>• Full Medicaid benefits<br>• Medicare Savings Program | Automatically qualify | State files | • Qualify for a full calendar year<br>• 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 through the year<br>• Extra help can increase, decrease, or terminate |

Once a beneficiary becomes deemed eligible, s/he is deemed, at a minimum, through the end of the current calendar year (December 31st), even if s/he is no longer eligible for Medicaid, a Medicare Savings Program or SSI. In August of each year, CMS determines if individuals who are deemed eligible for LIS during the current calendar year will continue to be deemed eligible for the subsequent calendar year. This "re-deeming" process for Medicaid and Medicare Savings Program participants begins with the month of July and continues through the calendar year. If an individual is Medicaid eligible in any month during the period July through December, the individual is deemed LIS eligible for the months of Medicaid eligibility and for any subsequent months of the period as well as for the subsequent year. Thus, for example, if a beneficiary is reported as Medicaid eligible for the month of March, then CMS will deem him/her March 1 through December 31 of the same calendar year. On the other hand, if a beneficiary is reported as Medicaid eligible for the month of August, then CMS will deem him/her August 1 through December of that same calendar year and January 1 through December 31 of the subsequent calendar year.

## Background on Best Available Evidence Policy

Best available evidence policy is used when the low-income subsidy information in CMS' systems is not correct. CMS relies on monthly files from the states and Social Security to establish an individual's low-income subsidy deemed eligibility and appropriate cost-sharing level. In certain cases, CMS systems do not reflect a beneficiary's correct LIS deemed status. This may occur, for example, because a state has been unable to successfully report the beneficiary as Medicaid eligible or is not reporting him/her as institutionalized.

CMS implemented the policy requiring Part D plan sponsors to use "best available evidence" under these circumstances to substantiate a beneficiary's correct cost-sharing level. This policy was first articulated in a memorandum to all Part D sponsors dated May 5, 2006, which also instructed sponsors to retain appropriate records of the evidence used to support plan-initiated changes in cost-sharing in order to reconcile low-income subsidy (LIS) payments with CMS.

On December 6, 2006, in a memorandum to all Part D sponsors, we provided instructions for implementing this policy for 2007. We state therein that plans must no longer default to LIS status without applying the best available data policy requirements. We also note, however, that plans may initially rely on evidence presented at the pharmacy to provide a lower cost-sharing status at point-of-sale, but must follow up with additional documentation within a specified period of time. We recommend that sponsors consider this approach to address urgent situations. In these cases, if the plan sponsor is unable to substantiate a basis for the beneficiary's lower cost-sharing status, the plan must use the CMS-provided subsidy level and send a notice to the beneficiary to recover the cost-sharing that should have been paid by the member during the discrepant period. Plan sponsors must collect documentation confirming the beneficiary's dual status (and $0 co-payment level for institutionalized dual eligibles) no later than the last day of the 2nd month after the month of the onset of default cost-sharing.

In that December 6 memorandum, we also announced plans to implement the necessary modifications to our systems to permit CMS to input a beneficiary's correct LIS deemed status once the plan sponsor obtained and submitted documentation substantiating the beneficiary's dual eligible status. As noted, this process will allow CMS and plan subsidy level records to be synchronized for those beneficiaries for whom Medicaid status has not been updated.

This document provides guidance to Part D plan sponsors on the procedures for initiating corrections to beneficiary LIS levels in cases in which the plan has documentation that constitutes "best available evidence" (BAE) about a beneficiary's Medicaid eligibility or residence in an institution under a Medicaid-covered stay. There will be a separate, yet to be developed, process for cases involving beneficiaries who have been awarded LIS by the Social Security Administration (SSA), but whose eligibility is not reflected in CMS systems. In the interim for these latter cases, Part D plan sponsors are still required to maintain members' LIS status on the basis of the SSA award letter; the appendix to this

document provides guidance on using the SSA award letter to determine whether the beneficiary is eligible for the full or partial subsidy.

## Procedures for Initiating LIS Status Corrections

To initiate LIS status corrections, Part D plan sponsors must follow best available evidence guidance and collect documentation to substantiate the beneficiary's LIS status. In addition, plan sponsors must:

a. Override standard cost-sharing and maintain an exceptions process for that beneficiary until the CMS LIS correction is processed. We recommend that sponsors use the same cost-sharing level as will be reflected in the CMS system once the manual correction is processed; that is: $1/$3.10 for full-benefit dual eligible individuals, and $2.15/$5.35 for partial dual eligible individuals.
   Plan sponsors must put processes in place that obviate the need to require the re-submission of documentation each month pending the correction of the beneficiary's LIS status in CMS systems. Such processes should compare subsequent CMS reports with the BAE-based status to ensure that the sponsor does not incorrectly override the BAE-based status.

b. Develop appropriate member services and pharmacy help desk scripting to triage cases involving BAE. CMS recommends that plan sponsors' BAE policies and procedures address the urgency of certain cases; e.g. a patient who is unable to access his/her antihypertensive medication. Plan sponsors should prioritize urgent cases, educate their contracted pharmacies about their process for handling urgent cases, and develop possible stop-gap solutions, such as providing a temporary fill.

c. Verify that CMS's systems do not already reflect the beneficiary's correct Medicaid/Medicaid institutional status for the purposes of establishing appropriate low-income cost-sharing status prior to a submitting a request for correction. Verification may be accomplished by checking the most recent bi-weekly LIS report from CMS or via the MARx User Interface.

### *Required Documentation*

Plan sponsors must obtain documentation to support a change to the beneficiary's LIS status. To establish Medicaid status at the high or low cost-sharing levels, the plan sponsor must obtain one or more of the following documents confirming the plan verified Medicaid eligibility:

1. A copy of the member's Medicaid card which includes the member's name and an eligibility date during the discrepant period;

2. A report of contact including the date a verification call was made to the State Medicaid Agency and the name, title and telephone number of the state staff person who verified the Medicaid status during the discrepant period;
3. A copy of a state document that confirms active Medicaid status during the discrepant period;
4. A print out from the State electronic enrollment file showing Medicaid status during the discrepant period;
5. A screen print from the State's Medicaid systems showing Medicaid status during the discrepant period; or
6. Other documentation provided by the State showing Medicaid status during the discrepant period.

To establish that the beneficiary is institutionalized and qualifies for a zero cost-sharing level, the plan sponsor must furnish one or more of the following forms of proof:

1. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period;
2. A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
3. A 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 the discrepant period.

# Transmitting an LIS Status Correction Request to CMS

## *Timing of LIS Status Correction Requests*

The manual LIS status correction process is not intended to supplant state MMA data files, in which states report their dual eligible beneficiaries to CMS between the 15th and the end of each month. CMS suspects that a manual update will not be necessary in all cases, as updated information on a subsequent state MMA file may automatically correct the data in CMS systems.

Prior to submitting a correction request, plan 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 month will be deemed for LIS via the normal process within the next several weeks.

## *LIS Status Correction Request*

LIS Status Correction Requests must be submitted to CMS via an Excel file. CMS recommends that plan sponsors establish a schedule for the monthly transmission of these requests. Each Excel file should contain information for all beneficiaries identified since the most recent prior request as requiring an LIS status correction. In other words, the correction request file should not be a cumulative record of previously submitted beneficiaries. The

required Excel file format for the request is shown below; a copy of this file format in Excel is attached.

Prior to submitting the request, plans should ensure that all beneficiary identifying information, such as name, date of birth, and HICN, is correct.

**Excel Format for LIS Status Correction Requests**

| | |
|---|---|
| Organization Name: | Primary Contact Name: |
| Contract Number: | Primary Contact Phone: |
| Organization Mailing Address: | Primary Contact E-Mail Address: |
| | Secondary Contact Name: |
| | Secondary Contact Phone: |
| | Secondary Contact E-Mail Address: |

**Request to Update CMS Medicaid Cost-Sharing Information**

| Bene Health Insurance Claim Number | Bene Last Name | Bene First Name | Bene Date of Birth | Bene Gender | Bene State of Residence |
|---|---|---|---|---|---|
| | | | | | |

| Start of Medicaid/ Medicaid Institutional Status (MM/CCYY) | Dual Eligible Status (Full/ Partial) | Institutional Status (Yes/No/ Unknown) | Type of Documentation Supporting Request | Description of "Other" State Documentation |
|---|---|---|---|---|
| | | | | |

## Certification and Cover Memo

A certification of the request signed by an authorized representative of the Part D plan sponsor must be submitted to CMS and is available in the Certification worksheet that is included in the "Plan Requests for LIS Change" workbook attached. The required certification is shown below.

"I have read the contents of the LIS Status Correction Request dated (indicate month, day and year) for the above-stated Part D plan contract number and attest that the information contained herein, based on best knowledge, information, and belief as of the

date indicated below, is true, correct, and complete, and that our organization will retain the original supporting documentation for requested changes for as long as it is required under our regulations and for as long as it may be required for subsequent Government audit. I further certify that I am an authorized representative of the business organization that is a Medicare Part D sponsor."

_____ _____

Plan Sponsor Signature Date

Once the certification is signed, the document should be scanned, saved as a pdf. file and attached to the email that must be used to transmit each Excel correction request file. The transmittal email must include the plan sponsor's contract number (H#, S#, R#).

## *Transmission Security Requirements*

To ensure the security of the beneficiary information contained in the Excel spreadsheet, the document must be encrypted using a Federal Information Processing Standards approved encryption method. Once encrypted, the file should be attached to transmittal email containing the information or a cover memo as specified above and submitted to the appropriate CMS regional office.

The plan sponsor must send the password for the encrypted file to the regional office in a separate email.

## *Regional Office*

CMS has designated an electronic mailbox in each regional office to which LIS Status Correction Requests must be sent. The RO mailbox addresses are listed below. Primary and secondary contact persons in each region are also provided, however these individuals should be contacted exclusively to address plan questions/issues that may arise relative to this process.

| CMS Region | Request Mailbox | Primary Contacts | Back-up Contacts |
|---|---|---|---|
| 1<br>Boston | PartDComplaints_RO1@cms.hhs.gov | Arlene DiSalvo<br>Arlene.DiSalvo@<br>cms.hhs.gov<br>617-565-1269 | Estella Ramirez<br>Estella.Ramirez@<br>cms.hhs.gov<br>617-565-1219 |
| 2<br>New York | PartDComplaints_RO2@cms.hhs.gov | Linda Sheo<br>Linda.Sheo@<br>cms.hhs.gov<br>212-616-2349 | Debra Smith<br>Debra.Smith@<br>cms.hhs.gov<br>212-616-2351 |
| 3<br>Philadelphia | PartDComplaints_RO3@cms.hhs.gov | Tammy McCloy<br>Tammy.McCloy@<br>cms.hhs.gov | Margaret Moon<br>Margaret.Moon@<br>cms.hhs.gov |

| CMS Region | Request Mailbox | Primary Contacts | Back-up Contacts |
|---|---|---|---|
| | | 215-861-4220 | 215-861-4754 |
| 4<br>Atlanta | PartDComplaints_RO4@cms.hhs.gov | Denise Stanley<br>Denise.Stanley@<br>cms.hhs.gov<br>404-562-7366 | Pam Miller<br>Pam.Miller@<br>cms.hhs.gov<br>404-562-7231 |
| 5<br>Chicago | PartDComplaints_RO5@cms.hhs.gov | Peter Bandemer<br>Peter.Bandemer@<br>cms.hhs.gov<br>312-886-2569 | Natosha Lee<br>Natosha .Lee@<br>cms.hhs.gov<br>312-353-1448 |
| 6<br>Dallas | PartDComplaints_RO6@cms.hhs.gov | Wanda Blakely<br>Wanda.Blakely@<br>cms.hhs.gov<br>214-767-4411 | Rose Marie Thoreson<br>RoseMarie.Thoreson@<br>cms.hhs.gov<br>214-767-6401 |
| 7<br>Kansas City | PartDComplaints_RO7@cms.hhs.gov | Peggy McQuitty<br>Peggy.McQuitty@<br>cms.hhs.gov<br>816-426-6547 | Filipe Pereira<br>Filipe.Pereira@<br>cms.hhs.gov<br>816-426-6385 |
| 8<br>Denver | PartDComplaints_RO8@cms.hhs.gov | Pamela Rivera<br>Pamela.Rivera@<br>cms.hhs.gov<br>303-844-6137 | Sandra Mendez<br>Sandra.Mendez@<br>cms.hhs.gov<br>303-844-1568 |
| 9<br>San Francisco | PartDComplaints_RO9@cms.hhs.gov | Jane Riney<br>Jane.Riney@<br>cms.hhs.gov<br>415-744-3759 | John Muglia<br>John.Muglia@<br>cms.hhs.gov<br>415-744-3593 |
| 10<br>Seattle | PartDComplaints_RO10@cms.hhs.gov | Brad Thuston<br>Brad.Thuston@<br>cms.hhs.gov<br>206-615-2427 | Sandie Ihrig<br>Sandie.Ihrig@<br>cms.hhs.gov<br>206-615-2377 |

The lead region model used for 1-800-Medicare complaint cases will be used for this process to determine the CMS RO to which plan sponsors should send the LIS status correction requests.

## *CMS Reporting to Plans*

Once CMS staff have completed action on the requests in the spreadsheet, CMS will complete the following three fields specified for CMS use and included in the attached Excel file format to report that the new data have been entered. A copy of the updated file will be returned to the plan sponsor's primary point of contact as reflected on the file.

| For CMS Only | | |
|---|---|---|
| Date Request Entered by CMS | Updated by | Comments |

### *Timing of CMS Systems Updates*

Once a correction request is processed by CMS, the new data will be stored in MBD. CMS systems will then update during the next monthly deeming process that occurs at the beginning of each month and the subsequent weekly TRR will report the updated information verifying the change has been implemented in CMS systems.

The Transaction Reply Code (TRC) 194 Deemed Copay Correction (DEEMD COPAY CORR) is the unique TRC for these manual updates indicating that CMS has added or updated a deemed co-pay period. The effective dates for the added or updated deemed co-pay period are shown in the TRR fields.

## Evidence Retention Requirements

Plan sponsors must maintain for 10 years the original documentation used to substantiate the request for manual updating of the CMS system to accommodate subsequent periodic Government audits.

An alternative to the Part D Plan Sponsor maintaining the BAE documentation would be for the 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 from the State, attest to the beneficiary's LIS status, and retain the documentation until requested by the plan to support an audit. Since the risk associated with the delegation would be on the plan sponsor, the business partner could be required to indemnify the sponsor for the incorrect cost-sharing amount if the partner was unable to produce the required documentation when requested by the sponsor.

## Impact of Subsequent State Reports on CMS Manual Updates

When subsequent reports are received from the State, CMS systems will compare the beneficiary's current LIS status information to the newly reported information. Changes

will be made to the beneficiary's LIS status only if the new information will be more advantageous to the beneficiary.

It is important to note that once the deeming request is processed, if a plan receives a subsequent CMS notification of new LIS status changes, this new information must be processed.

# Appendix – Using the SSA Award Letter to Determine Eligibility for the Full or Partial Subsidy

When a beneficiary applies and qualifies for LIS with Social Security, s/he is awarded either the full or partial subsidy based on their income and resources. SSA always provides the beneficiary with an award letter that explains if the award is for a full subsidy or a partial subsidy, a reduced deductible and reduced co-payments. If the award is for a partial subsidy, the letter explains the percentage of the subsidy award.

[All dollar figures below are 2007 amounts.]

- A full subsidy award means that the beneficiary can enroll in a plan that will pay the full premium up to the regional low-income premium benchmark amount. The beneficiary will pay no deductible and cost-sharing of covered prescriptions will be limited to $2.15/$5.35.
- A partial subsidy award letter will specify that the beneficiary is eligible for a subsidy of 25%, 50%, 75% or 100% of the regional low-income benchmark amount. The beneficiary will be responsible for a deductible of no more than $53 with cost-sharing (coinsurance) of 15% until the catastrophic limit is reached ($5,451.25). After the catastrophic limit is reached, co-pays will be $2.15/$5.35 for covered prescriptions.

Note that a beneficiary cannot be awarded a 75%, 50% or 25% premium subsidy and have no deductible.