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

CENTER FOR BENEFICIARY CHOICES

DATE December 6, 2006

Memorandum to: All Part D Sponsors

Subject: Reconciling CMS Low Income Subsidy (LIS) Status and "Best Available Data" Policy for 2006 and 2007

From: Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit Group

Early in 2006, a number of factors contributed to the problem of incorrect cost-sharing levels for full-benefit dual eligibles and other LIS eligible individuals. The purpose of this memorandum is to provide instructions for reconciling CMS LIS status and implementing the best available data policy[1] for 2006 and for 2007. This memorandum amends certain instructions issued in our October 30, 2006 memorandum entitled, "Implementing our Best Available Data Policy for Low-Income Subsidy (LIS) Status".

Instructions for 2006

SSA Subsidy Level Changes: For those LIS beneficiaries who were included on the October 30, 2006 Special LIS Resynchronization Report, continue to follow the instructions contained in the October 30, 2006 memorandum entitled, "Implementing our Best Available Data Policy for Low-Income Subsidy (LIS) Status".

Other LIS Changes: Contrary to the October 30th memorandum, do **not** follow the instructions in the October 30, 2006 memo in the subsection "If data places the individual in a less favorable status" for other beneficiaries for whom LIS status was defaulted based on prior CMS guidance. Instead, for those beneficiaries for whom LIS status was defaulted in 2006, who were not included on the October 30, 2006 Special LIS Resynchronization Report, and for whom CMS data files have never substantiated the default level, you must determine whether you have supporting evidence (i.e., currently meet criteria such as those outlined in Attachment I) to substantiate the continued adjudication of a subsidy status in accordance with the best available data policy and take one of two actions:

[1] In an effort to address issues associated with incorrect cost-sharing, CMS issued a memorandum to all Part D sponsors in May 5, 2006 directing plans to use the "best available data" when they had knowledge that a beneficiary's cost sharing level was not correct. Plans were instructed to keep appropriate records of the evidence supporting these changes in order to reconcile low-income subsidy payments with CMS.

1. If documented evidence is available to substantiate the defaulted status (see Attachment I), do not change the beneficiary's subsidy status (i.e., continue to adjudicate the benefit at the same level into 2007).

2. If substantiating information cannot be secured, change the member's LIS status to the status indicated in CMS files effective January 1, 2007, and

    - Plans must immediately send the attached model notice (see Attachment II) to inform beneficiaries that the default LIS will not continue into 2007 *(Note that contrary to the October 30, 2006 instructions, plans will not recoup the amount that was subsidized at the default LIS level).*

    - Plans will be permitted to report the actual LIS cost sharing charged on the PDEs for these individuals who were defaulted without documentation. However, since this will require further systems modifications to prevent the rejection of these data, PDE reporting instructions will be issued separately.

Plans will shortly be receiving two separate reports from CMS, one of which will identify beneficiaries who will be losing LIS status effective December 31, 2006 and the other reporting 2007 LIS status, if any, for all beneficiaries. Plans should review these reports to identify any beneficiaries for whom LIS status has been defaulted. If any of these beneficiaries is shown on either report as losing LIS effective December 31st or as having no or less favorable LIS status for 2007, plans must secure solid supporting documentation in order to continue the beneficiary under best available data policy. Individuals who do not qualify for a continued subsidy under the best available data policy must have their subsidy status be discontinued after 2006 and be handled according to the instructions in #2, above.

Instructions for 2007

For 2007, Part D plan sponsors must match the LIS subsidy status reflected in CMS files unless the best available data policy applies. Plans must no longer default to LIS status without applying the best available data policy requirements. If best available data policy requirements have been met, the plan must override CMS subsidy-level data and apply the appropriate cost-sharing level until CMS systems are updated to accurately reflect information about a beneficiary's dual eligibility.

In early 2007, CMS will be implementing a systems change that will permit CMS staff to manually input a beneficiary's correct LIS deemed status once the plan sponsor has obtained and submitted documentation confirming the beneficiary's dual eligible status. This process will allow CMS and plan subsidy level records to be synchronized for those beneficiaries for whom Medicaid status has not been updated within a certain period of time.

CMS will be finalizing the 2007 best available evidence policy and procedures for correcting low-income subsidy levels in the next several weeks. The following bullets describe the policy direction CMS is considering pending final guidance. Comments on this list and on other points

of clarification should be directed to your Trade Associations for consolidation and discussion with CMS.

- In general, while plans may initially rely on evidence presented at the pharmacy, they will need to follow up with additional documentation within a specified period of time. Specifically:

- **When confirming documentation is obtained:** For beneficiaries for whom confirming documentation is obtained (see Attachment I), the plan sponsor will continue the individual's lower cost-sharing status and relay the documentation to CMS for correction of CMS systems.

- **When confirming documentation cannot be obtained:** If the plan sponsor is unable to substantiate a basis for the beneficiary's lower cost-sharing status, the plan must reinstate the CMS-provided subsidy level. In these cases, plans will be required to send the attached model notice (see Attachment III) to recover excess cost-sharing paid on behalf of the member during the discrepant period.

- **Timeframe for obtaining documentation:** Plan sponsors must allow no more than the last day of the 2nd month, after the month of the onset of default cost-sharing, to collect documentation confirming the beneficiary's dual status (and $0 copayment level for institutionalized dual eligibles). For example, if a member presents evidence of his or her dual status at the pharmacy on February 2nd, the Part D plan sponsor needs to confirm status no later than the end of April.

For questions concerning the best available data policy and reconciling LIS cost-sharing, please contact Deborah Larwood at 410-786-9500.

Attachment I

Proposed Evidence Necessary to Document
A Necessary Change in Subsidy Level

Proof of Low-Income Subsidy Status:

- A copy of a member's Medicaid card with includes the member's name and the eligibility date during the discrepant period;
- A copy of a letter from the State or SSA showing Medicare Low-Income Subsidy status
- The date that a verification call was made to the State Medicaid Agency, the name and telephone number of the state staff person who verified the Medicaid period, and the Medicaid eligibility dates confirmed on the call;
- A copy of a state document that confirms active Medicaid status during the discrepant period; or
- A screen-print from the State's Medicaid systems showing Medicaid status during the discrepant period; or
- Evidence at point-of-sale of recent Medicaid billing and payment in the pharmacy's patient profile, backed up by one of the above indicators post point-of-sale.

Proof of Institutional Status for a Full-Benefit Dual Eligible:

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

Attachment II

2006 Model Notice of Error in Premiums and Cost Sharing

{*Plans: This letter is to inform a member of his/her new premiums and cost-sharing effective 1/1/2007. You will use this model to notify any members you had defaulted in 2006 to a lower cost-sharing status and for whom you never received confirmation from either the State Medicaid Agency or CMS that the member is Medicaid or LIS eligible. The marketing material code for this model notice is* ***7007****. If you use this model notice without modification, CMS will waive the five-day waiting period associated with file and use pieces.*}

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

<Date>

Dear <Name of Member>:

During 2006, <Plan name> has been charging you a copayment of [$0]/[up to $1 or $3]/[up to $2 or $5]/[15%] for each prescription you filled because we received information earlier this year that you might qualify for extra help with your prescription drug costs. However, to date the Medicare Program has not confirmed that you qualify for extra help.

Because <Plan name> has not been able to confirm that you qualify for extra help, your Medicare prescription drug costs are changing. Beginning January 1, 2007, you will pay:

- [insert plan premium] per month for your <plan name> premium,
- [insert deductible amount] for your yearly prescription drug plan deductible, and
- [insert amount] when you fill a prescription covered by <plan name>.

If you believe you still qualify for Medicaid, please call our Member Services at <phone number><days and hours of operation>. TTY users should call <TTY number>. We may ask to you send us proof of your Medicaid eligibility.

If you don't qualify for Medicaid, belong to a Medicare Savings Program, or receive Supplemental Security Income (SSI) benefits, 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 other questions, please call our Member Services at <phone number><days and hours of operation>. TTY users should call <TTY number>.

Thank you.

Attachment III

2007 Model Notice of Error in Premiums and Cost Sharing

{*Plans: This letter is to inform a member that s/he is liable for cost-sharing amounts you have paid on his or her behalf. Beginning in 2007, you will use this model to notify any members for whom you were unable to substantiate a basis for the member's lower cost-sharing status. The marketing material code for this model notice is* ***7008****. If you use this model notice without modification, CMS will waive the five-day waiting period associated with file and use pieces.*}

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

<Date>

Dear <Name of Member>:

Since <Date>, <Plan name> has been charging you a copayment of [$0]/[up to $1 or $3.10]/[up to $2.15 or $5.35]for each prescription you filled because you or your pharmacist informed us that you may qualify for extra help with your prescription drug costs. The Medicare Program has not confirmed that you qualify for extra help. <Plan name> has contacted your state Medicaid agency but has not been able to confirm that you qualify for extra help because you don't qualify for Medicaid.

Because <Plan name> has not been able to confirm that you qualify for extra help, your Medicare prescription drug costs are changing. Effective <Date>, you will pay

- [insert plan premium] per month for your <plan name> premium,
- [insert deductible amount] for your yearly prescription drug plan deductible, and
- [insert amount] when you fill a prescription covered by <plan name>.

The Medicare Program requires <plan name> to charge you for past prescription drug costs for any premiums, deductible or cost sharing amounts you should have paid since <date>. <Plan name> will send you a notice telling you what you owe for past charges.

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>.

Thank you.