Department:	Medicare Operations	**Original Approval:**	11/25/2008
Policy & Procedure No:	EM114	**Last Approval:**	02/18/2026
Policy & Procedure Title:	Best Available Evidence Policy and Procedure		
Approved By:	Charyl Norwood – Vice President of Customer Experience		
Dependencies:	N/A		

Purpose

The purpose of this document is to describe the Community Health Plan of Washington (CHPW) policy and procedure for using Best Available Evidence (BAE) to update member low-income subsidy (LIS) information.

Policy & Procedure

CHPW will follow the guidance in the Centers for Medicare and Medicaid Services (CMS) Medicare Prescription Drug Benefit Manual Chapter 13 Section 70.5 for determining appropriate cost-sharing subsidies for Part D eligible individuals who do not have one of the required pieces of evidence but who claim to be eligible for the LIS. These requirements apply to all beneficiaries who are "deemed" subsidy eligible (including full benefit Medicare/Medicaid eligible, partial dual eligible, and people receiving Supplemental Security Income (SSI) as well as those who must apply and are awarded LIS by the social Security Administration (SSA).

CHPW will accept specified forms of documentation of a member's correct LIS status, to change the member's cost-sharing levels in CHPW's system based on that documentation, and for deemed LIS beneficiaries to submit to Health Plan Management System's Complaints Tracking Module.

CHPW will accept any of the following forms of evidence to establish the subsidy status of a full benefit dual eligible member when provided by the member or other individual acting on behalf of the member. CHPW will include a copy of one of the following Best Available Evidence (BAE) documents with every update request submitted to CMS:

1. A copy of the member's Medicaid card that includes the member's name and eligibility date during a month after June of the previous calendar year;
2. A copy of a state document that confirms active Medicaid status during a month after June of the previous calendar year;

Data contained in this document is considered confidential and proprietary information and its duplication, use, or disclosure is prohibited without prior approval of Community Health Plan of Washington.

3. A printout from the State electronic enrollment file showing Medicaid status during a month after June of the previous calendar year;
4. A screen print from the State's Medicaid systems showing Medicaid status during a month after June of the previous calendar year;
5. Other documentation provided by the State showing Medicaid status during a month after June of the previous calendar year;
6. A letter from SSA showing that the individual receives SSI denoting the effective date; or,
7. An Important Information letter from SSA confirming that the member is "automatically eligible for extra help", which denotes the effective date

CHPW will accept any one of the following forms of evidence from member or pharmacists to establish that a member is institutionalized 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;
- A 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; 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 a month after June of the previous calendar year.

Additionally, if a member is receiving home and community-based services (HCBS) and qualifies for zero cost-sharing the following will be accepted:

- A State-issued notice of action, determination or notice of enrollment that includes name and HCBS eligibility date from June of the previous year forward
- A state approved HCBS service plan that includes the name and effective date, from the June of the previous year forward
- State-issued prior authorization approval letter for HCBS that includes the name and an effective date from June of the previous year forward

Data contained in this document is considered confidential and proprietary information and its duplication, use, or disclosure is prohibited without prior approval of Community Health Plan of Washington.

- Other documentation provided by the state showing both HCBS eligibility status from June of the previous year forward or a state-issued document confirming payment to HCBS, with name and dates of HCBS

1. As soon as one of the forms of BAE listed above is presented, CHPW will provide the member 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, or at zero cost-sharing if the BAE also verifies the member's institutional status.
2. CHPW will update (Xcelys and ESI) systems within 24-72 hours of receipt of BAE documentation to reflect the correct LIS status, override standard cost-sharing and maintain an exception process for the member to obviate the need to require the re-submission of documentation each month pending the correction of the member's LIS status in CMS system. In addition, CHPW will provide access to covered Part D drugs as soon as the BAE is presented.
3. CHPW will verify that CMS' systems do not already reflect the member's correct LIS status. If CMS' systems do not already reflect the updated information for "deemed" beneficiaries, CHPW will submit a request for correction.

ASSISTING INDIVIDUALS WITHOUT BAE DOCUMENTATION:
CHPW will take the following actions to assist members who claim to be subsidy eligible based on being full or partial dual eligible but who cannot provide the documentation described above:

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 the following:
    a. Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI)
    b. Beneficiary's First and Last Name
    c. Beneficiary's Address
    d. Beneficiary's Date of Birth
    e. Issue Level. If the beneficiary has less than 3 days of medication remaining, select "Immediate Need." If the beneficiary has 3-14 days

Data contained in this document is considered confidential and proprietary information and its duplication, use, or disclosure is prohibited without prior approval of Community Health Plan of Washington.

of medication remaining, select "Urgent." For all other situations, select "No Issue Level"

f. 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:

    a. Resolution
    b. Start of Medicaid/ Medicaid Institutional Status (MM/CCYY)
    c. Dual Eligible Status (Full/Partial)
    d. Institutional Status (Yes/No/ Unknown)
    e. LIS Co-Pay Level
    f. 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:

    a. 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.
    b. 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

Data contained in this document is considered confidential and proprietary information and its duplication, use, or disclosure is prohibited without prior approval of Community Health Plan of Washington.

provided here as Attachment B. o 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.

c. 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 eligible, 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.

In cases where there is a CTM, CHPW will close out the case in the CTM in the new "Beneficiary Needs assistance with Acquiring Medicaid Eligibility Information" category. The date entered must be the date of CHPW's final attempt to notify the member of the results of CMS' inquiry, in accordance with the procedures described above.

List of Appendices

None

Data contained in this document is considered confidential and proprietary information and its duplication, use, or disclosure is prohibited without prior approval of Community Health Plan of Washington.

Citations & References

CFR		
WAC		
RCW		
LOB & Contract Citation	☐ **WAHIMC**	
	☐ **BHSO**	
	☐ **Wraparound**	
	☐ **SMAC**	
	☐ **HH**	
	☐ **AHE**	
	☒ **MA/DSNP**	Medicare Prescription Drug Benefit Manual Chapter 13 § 70.5
	☐ **CS**	
Other Requirements		
NCQA Elements		

Revision History

SME Review:	11/14/2008, 11/25/2008, 07/01/2011, 09/18/2012, 04/15/2014, 04/01/2015, 03/22/2016, 02/24/2017, 02/16/2018, 02/20/2018, 02/19/2019, 02/13/2020, 02/11/2021, 02/11/2022, 02/21/2023, 02/19/2024, 02/18/2025, 02/18/2026
Approval:	11/25/2008, 08/18/2011, 10/01/2012, 03/27/2015, 03/22/2016, 02/24/2017, 02/20/2018, 02/19/2019, 02/13/2020, 02/11/2021, 02/11/2022, 02/21/2023, 02/19/2024, 02/18/2025, 02/18/2026

Data contained in this document is considered confidential and proprietary information and its duplication, use, or disclosure is prohibited without prior approval of Community Health Plan of Washington.