★ ★ TIP SHEET ★ ★

Information Partners Can Use on:

Correcting Beneficiary Low-Income Subsidy Status Based on Best Available Evidence

Medicare Prescription Drug Coverage **Revised December 2008**

Medicare uses data from states and Social Security to determine the level of extra help a person qualifies for (their premium and copayment levels). Sometimes, Medicare's systems may show incorrect copayment levels, or they may not show that an eligible person qualifies for extra help. This discrepancy may happen when a person's Medicaid or institutionalized status has not yet been successfully reported by the state.

Medicare drug plan sponsors are required to use "best available evidence" (BAE) to correct information about a person's level of extra help. Once plans receive BAE documentation, they can't charge a person more than $2.40 for each generic drug (or brand-name drug treated as a generic) or $6.00 for any other brand name drugs (in 2009). People with Medicaid who live in an institution (like a nursing home) should pay zero for their covered drugs. If a person thinks they qualify for extra help because they have Medicaid, but they don't have or can't find the BAE documentation and ask for help, the plan must refer the person's information to Medicare to confirm the person qualifies.

How to Use BAE

You can help a person make sure they pay the right amount for their prescriptions by following the steps below. Be sure the person has the following personal information available:

- Name
- Date of Birth
- Medicare Health Insurance Claim Number

Then simply follow these steps:

Step 1. Collect documentation that meets the definition of BAE (see the chart below).

Step 2. Send the BAE documentation to the plan.

Step 3. If the person can't find or doesn't have any BAE documentation, contact their plan and specifically ask for help getting the documentation.

Step 1: Collect BAE Documentation

You can provide any of the following documents to plans to verify a person's eligibility for extra help and help the plan correct the person's low-income subsidy status or copayment level:

- Automatic enrollment letter from Medicare on yellow or green paper
- Letter from Medicare on purple paper that says the person automatically qualifies for extra help
- Letter from Medicare on orange paper that says the amount of the person's copayment will change next year
- Extra help "Notice of Award" from Social Security
- Other proof that the person qualifies for extra help, such as an award letter from Social Security as proof that the person has Supplemental Security Income (SSI)

You can also provide any of the documents listed below as proof that the person qualifies for extra help. Each item listed below must show that the person was eligible for Medicaid during a month after June 2008.

Proof of Medicaid	Proof of Medicaid and Institutionalization
• A copy of the person's Medicaid card that includes the person's name and eligibility date • A copy of a state document that confirms active Medicaid status • A printout from the state's electronic enrollment file or screen print from the state's Medicaid systems showing Medicaid status • Other documentation provided by the State Medicaid Assistance (Medicaid) office showing Medicaid status	• A bill from the facility showing Medicaid payment for the person for a full calendar month • A copy of a state document that confirms Medicaid payment to the facility for the person for a full calendar month after June 2008 • A screen print from the state's Medicaid systems showing the person's institutional status for at least a full calendar month after June 2008

Step 2: Submit BAE Documentation to the Plan

Call the person's plan, or visit the plan's website to find out where to mail or fax the documents, or if they can be sent by e-mail.

As soon as the plan receives any one of the documents listed above, it must make sure the person pays no more than $2.40 for each generic drug (or brand-name drug treated as a generic) or $6.00 for any other brand-name drug (in 2009). If the documents also verify the person has Medicaid and lives in an institution, the plan must make sure the person pays nothing for their prescription drugs.

The plan must also work with Medicare to correct the discrepancy in their systems. Until the problem is corrected, the plan must make sure the person continues to be charged only the corrected cost-sharing amounts without having to resubmit documentation each month.

Step 3: Contact the Plan for More Help

If a person can't locate any of the documents listed above as proof of their Medicaid or institutional status, contact the plan and ask for help getting the documentation. The plan will refer the person's information to Medicare to verify the person's status. When you contact the plan, be sure to tell them how many days of medication the person has left. The plan will include this information in its request to Medicare so that Medicare can respond before the person runs out of medication, if possible. The plan generally must refer requests to Medicare within one business day of receiving them. Once Medicare responds, the plan must attempt to notify the person of the results within one business day. The request will take anywhere from several days to up to two weeks to process, depending on the circumstances, including the urgency of the beneficiary's need for medication.

You should also contact the plan for information to help people get reimbursed for any expenses they may have paid out-of-pocket during any retroactive months they qualified for extra help.

What if the plan won't fix the problem?

If the plan doesn't correct a problem to make sure the person pays the right amount, or if the plan doesn't work with you to help get proof of Medicaid or institutional status, or if the plan fails to respond within normal timeframes, call 1-800-MEDICARE (1-800-633-4227) to file a complaint. TTY users should call 1-877-486-2048.

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