

■ **eAppendix A. Mandatory Requirements for Accepting Best Available Evidence**

Part D plan sponsors are required to accept any of the following forms of evidence to establish the subsidy status of a full-benefit, dual-eligible beneficiary when this evidence is provided by the beneficiary or the beneficiary's pharmacist, advocate, representative, family member, or other individual acting on behalf of the beneficiary:

1. A copy of the beneficiary's Medicaid card that includes the beneficiary's name and an 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;
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; or
6. For individuals who are not deemed eligible, but who apply and are found to be eligible for the low-income subsidy, a copy of the award letter from the Social Security Administration.

For institutionalized beneficiaries, plans are required to accept any one of the following forms of evidence from beneficiaries or pharmacists to establish that a beneficiary is institutionalized and qualifies for zero cost-sharing:

1. 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;
2. 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
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 a month after June of the previous calendar year.

Source: Reference 12.

■ **eAppendix B. New Process for Assisting Individuals Without Best-Available-Evidence Documentation**

1. Complete a CMS BAE assistance worksheet that contains both beneficiary and plan sponsor information. The plan sponsor will need to include on the spreadsheet when the beneficiary will run out of medication. If the beneficiary has fewer than 3 days of medication, the worksheet must be submitted with the subject line containing the phrase "immediate BAE assistance needed."
2. Submit the worksheet via encrypted e-mail to the CMS regional office based on where the beneficiary resides within 1 business day of being notified by the beneficiary.
3. Upon receipt of the returned worksheet from CMS, plan sponsors must update their systems and notify members of the eligibility information within 1 business day of finding the results. If the plan sponsor is unable to reach the beneficiary, the plan sponsor must continue until they make 4 attempts. The fourth attempt must be in writing using a CMS model letter.

BAE indicates best available evidence; CMS, Centers for Medicare & Medicaid Services.
Source: Reference 12.

■ **eAppendix C. Medication Therapy Management Program Changes**

1. Part D sponsors may make positive changes to the plan-designed eligibility criteria for multiple chronic diseases, multiple covered Part D drugs, or analytical procedures used to determine if a beneficiary is likely to incur annual costs in excess of a predetermined level as specified by the secretary. These changes would make the eligibility more inclusive and could increase the number of beneficiaries eligible to receive Part D MTM services. Positive changes may include decreasing the minimum number of multiple chronic diseases, expanding the list of specific chronic diseases that apply, decreasing the minimum number of multiple covered Part D drugs, or expanding the list of specific covered Part D drugs, or types of drugs, that apply.
2. Part D sponsors may make program enhancements or maintenance changes that include changes to the method of beneficiary enrollment/disenrollment or identification to increase or promote ease of beneficiary participation, expand the levels of intervention or service provided to participating targeted beneficiaries, or methods of documenting and measuring outcomes.
3. Medication Therapy Management Program Changes Part D sponsors may change the provider of MTM services, or any fee schedules established for pharmacists and other MTM providers if using outside personnel. CMS will request that Part D sponsors disclose the newly established fees for outside personnel.
4. Medication Therapy Management Program Changes Part D sponsors may not make any negative changes to their MTM program. While the following list is not exhaustive, potentially negative changes include: changes that promote discriminatory or exclusionary practices, decrease the number of enrollees eligible for MTM services, or lower quality or robustness of MTM services.

CMS indicates Centers for Medicare & Medicaid Services; MTM, medication therapy management.
Source: Reference 14.