Q: CMS instructed Part D plans on May 5, 2006 that they are required to use the "best available data" to make changes to their systems when they have knowledge that a dual eligible beneficiary's cost sharing level is not correct. What does CMS mean by best available data?

A: Part D plans have flexibility to develop their own procedures for determining whether best available information is sufficient to change or update their systems to reflect appropriate cost sharing levels for dual eligibles. For example, with respect to dual eligibles who are community residents, a Part D plan may rely on the beneficiary showing the contracted pharmacy a current Medicaid card or on information provided by a state Medicaid office as proof of low-income subsidy status. Since the Part D plan will not know the exact subsidy level for the dual eligible beneficiary, it should default the enrollee to a $2/$5 benefit package.

For full benefit dual eligibles who are residents of long term care (LTC) facilities, a plan may develop procedures that rely on attestations from LTC pharmacy and facility personnel that certain residents who are enrollees of the plan are Medicaid eligible, have been or are expected to be residents of the facility for a full calendar month, and are under a Medicaid-covered stay. For LTC facility residents, Part D plans should rely on information that clearly indicates the elements necessary to confirm Medicaid eligibility and LTC facility admission dates for purposes of establishing a full calendar month of LTC facility residency. This could include location codes on billing transactions from the LTC pharmacies, in conjunction with the institutional attestations necessary to confirm Medicaid eligibility and LTC facility admission dates for a Medicaid-covered inpatient stay. As part of their procedures, Part D plans should keep appropriate records in order to reconcile low-income subsidy payments with CMS after the end of the contract year.