

March 2007
National Edition

Low-Income Advocate Alert On Medicare Part D

In 2007, advocates for low-income seniors and people with disabilities report that the operation of Medicare Part D is smoother and less chaotic than it was a year ago. Very serious problems remain. This issue of the National Advocates' Alert on Medicare Part D highlights some of the issues that arise most frequently, as well as provides practical tips for advocates about:

- People entitled to the **Low Income Subsidy** (LIS or “extra help”) being charged incorrect cost-sharing at the pharmacy. Page 2.
- Updated policies and procedures for those who **lost the Low Income Subsidy** in 2007. Page 5.
- Drug plan sponsors marketing **Medicare Advantage** plans to dual eligibles and others using improper or fraudulent marketing techniques. Page 6.
- Problems caused by **incorrect automatic withholding of Part D premiums** from enrollee's Social Security payments. Page 10.

The National Alert reviews new rules and policy documents issued by the Centers for Medicaid and Medicare Services in the last three months. In addition, the Alert discusses important news and tools recently released or updated by the National Senior Citizens Law Center and other organizations that can help advocates in the field deal with Medicare Part D problems, including:

- An update on **Situ v. Leavitt**, a class action lawsuit against the federal government filed on behalf of dual eligible Medicare beneficiaries. Page 11.
- A new California report on **language access** showing that Part D drug plans often fail to serve limited English proficient beneficiaries in their primary language. Page 13.
- An updated tool on **Low Income Subsidy regulations and procedures**. Page 16.
- An updated tool on CMS Guidance on **eligibility, enrollment and disenrollment**. Page 16.

I. IMPORTANT INFORMATION

A. LOW INCOME SUBSIDY COST-SHARING PROBLEMS

Advocates continue to report that beneficiaries of the Low Income Subsidy (LIS) encounter difficulties getting the correct cost-sharing subsidy at the pharmacy counter. The LIS, also called “extra help,” is a benefit available automatically to dual eligibles (those entitled to both Medicare and full Medicaid benefits), Medicare Savings Program enrollees, and SSI recipients. Many other low-income individuals qualify for the LIS by affirmatively applying with the Social Security Administration or a state Medicaid office. Most LIS beneficiaries are entitled to co-pays of \$0-\$5.35 on all prescription drugs. NSCLC has heard stories of low income beneficiaries who have been forced to overpay for or go without needed medications because their plan has not received information from the Centers for Medicare and Medicaid Services (CMS) indicating that they are eligible for the Low Income Subsidy.

We are working to address LIS delay issues and are interested in hearing about specific examples. Please contact us as soon as possible if you have experienced problems of this type (Anna Rich, 510-663-1055, ext. 303 or arich@nsclc.org).

☞ For more information about the LIS, see NSCLC’s recently revised tool, “The Low Income Subsidy (LIS) for Medicare Part D Enrollees,” available online at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.4596471630.

Best Available Data Policy

As mentioned in the December National Alert, according to CMS’ most recent guidance, plans are supposed to apply a “best available data” policy, allowing recipients who can document their LIS status to receive the subsidy immediately. Beneficiaries who are entitled to LIS therefore should take all possible evidence of their eligibility (e.g., state Medicaid card, or a letter from the state Medicaid agency or SSA showing LIS status) with them to the pharmacy. As explained in the December Alert, CMS states that it will require plans to recoup the amount of any subsidy received if an individual is later unable to confirm LIS eligibility.

So far in 2007, advocates report that pharmacists are generally unaware of the best available data policy, and that plans often refuse to apply the best available data policy by accepting a beneficiary’s evidence of LIS eligibility. In some CMS regions, advocates and beneficiaries who manage to connect with the right regional official are able to get their Part D plan to recognize LIS status relatively quickly. In other parts of the country, however, advocates have been told just to “wait for the system to correct itself.” Furthermore, the best available data policy applies to Part D plans only, not to pharmacists, so using the policy to get around an LIS delay always requires advocacy directly with a Part D plan.

☞ CMS' recent memo on "Reconciling CMS Low Income Subsidy (LIS) Status and 'Best Available Data' Policy for 2006 and 2007" (December 6, 2006) is available online at http://www.nslc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.1399747428.

New Strategy: Coverage Determinations

Another approach to LIS cost-sharing problems is to file a coverage determination request. The latest version of the *Medicare Prescription Drug Benefit Manual, Chapter 18 – Part D Enrollee Grievances, Coverage Determinations, and Appeals* (see link in Section IV below) makes it clear that plans "must subject complaints about co-payments to the coverage determination process when an enrollee believes that a Part D plan sponsor has asked him or her to pay a different cost-sharing amount than the enrollee believes he or she is required to pay for a prescription drug" (Chapter 18, p. 17). CMS regional staff has informally agreed that LIS co-payment issues are subject to the coverage determination process. Generally, however, plans are not handling subsidy problems through coverage determination channels, and advocates have not been asking for such treatment.

Advantages to filing coverage determinations to resolve LIS discrepancies:

- **Deadlines:** Coverage determinations have deadlines: 72 hours for a standard request; 24 hours for an expedited request. Weekends and holidays count towards the deadlines, so using the coverage determination process could be particularly helpful if a problem arises on a Friday or in a holiday period. If the beneficiary has already paid the incorrect higher co-pay and is seeking reimbursement, the plan must make a decision within 72 hours and must mail the refund of the overpayment within 30 calendar days of the request.
- **Expedited treatment:** If a beneficiary cannot get access to needed drugs because he or she cannot afford the non-LIS co-pay, and if the treating physician certifies that waiting for a decision under the standard time frame "may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy," then the plan must make a coverage determination within 24 hours. NOTE: Nothing more is required of the physician other than making the certification, which can be done orally. Because a co-payment coverage determination is not an exception, no other supporting statement about the need for the drug is required.
- **Dedicated plan personnel:** Coverage determination staff, with dedicated phone and fax numbers may be more responsive than plan customer service representatives (CSRs).
- **Documentation:** If a plan denies a coverage determination, the reason for the denial must be stated in writing.

- Appeal rights: All coverage determination appeal rights would apply. Moreover, if the plan fails to meet its deadlines, the case file must be sent directly to the IRE within 24 hours.
- Statistics: CMS requires reporting of coverage determination requests and their outcomes.

Possible disadvantages to filing coverage determinations to resolve LIS discrepancies:

- Unfamiliarity: Coverage determination staff may not know much about LIS issues so may not be able to address them quickly. They may need to be educated.
- Responsibility: If the problem is more complex than simply getting the plan to accept best available evidence, the solution may lie with entities other than the plan. Working through CMS may be more effective in some cases.

Advocates can also try filing a coverage determination when pursuing retroactive reimbursement of incorrect co-pays in other situations. Since a request for retroactive reimbursement requires a decision by the “Part D plan sponsor regarding payment or benefits to which an enrollee believes he or she is entitled” it should be treated as a coverage determination. Requests for premium refunds, however, appear to be outside of the scope of the coverage determination process.

Please report back. If you request a coverage determination, let us know what happens. Contact Georgia Burke at NSCLC, (510) 663-1055, ext. 304, or gburke@nslc.org.

☞ For a more detailed discussion of coverage determinations and appeal rights generally, see NSCLC’s “Exceptions and Appeals: A Practical Guide,” available online at www.nslc.org/areas/medicare-part-d/area_folder.2006-09-28.4596471630.

B. LATE ENROLLMENT PENALTY WAIVED FOR 2007 LIS RECIPIENTS

On January 8, 2007, CMS announced that there will be no Late Enrollment Penalty in 2007 for individuals eligible for the Low Income Subsidy. The Late Enrollment Penalty would normally be applied to any individuals who failed to sign up for Medicare Part D during their initial enrollment period, went without creditable coverage for a period of 63 days and subsequently signed up for a Medicare Part D plan. The decision not to apply the penalty to LIS beneficiaries means that individuals who are found eligible for the subsidy and sign up for a Part D plan by December 31, 2007 will never face a Late Enrollment Penalty, even if they could have signed up for a plan much earlier.

CMS had earlier waived the Late Enrollment Penalty for LIS beneficiaries who enrolled late in 2006.

C. UPDATES FOR THOSE LOSING LIS IN 2007

SSA Redetermination Update

As described in the December National Alert, the Social Security Administration conducted a review process to redetermine LIS eligibility in 2007 of individuals who applied and were found eligible for the LIS in 2006. CMS has announced that the Social Security Administration (SSA) has finished its initial round of redeterminations. Individuals whose LIS eligibility will change or terminate as a result of a redetermination were notified by SSA that the change or termination would take effect on February 1, 2007. Individuals who were sent, but failed to return the Form 1026B, will receive a notice indicating that their benefits will terminate effective March 1, 2007.

Because SSA is required to send all notices before the effective date of the termination in order to provide beneficiaries with sufficient time to file an appeal, those who lost LIS through the redetermination process should have received a notice by now. Individuals who disagree with SSA's decision can file an appeal. Individuals who file their appeals within 10 days after receiving a notice can continue to receive the benefits of the LIS pending the outcome of the appeal. 20 C.F.R. § 418.3615.

SSA will continue to process redeterminations as beneficiaries return 1026B forms and SSA verifies information received from beneficiaries. All decisions made by SSA regarding eligibility will be prospective. Beneficiaries will receive notices of any reduction or termination of benefits. Redeterminations are conducted throughout the year for beneficiaries who report a change in marital status. Any change in LIS eligibility which is a result of a change in marital status will be effective the month following the month in which the change is reported.

☞ For a copy of the CMS memorandum on “Redetermination of Low Income Subsidy (LIS) Eligibility for 2007” see http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2240438420.

☞ For more detailed information about redeeming and redetermination, see NSCLC's guide for advocates, “The Low Income Subsidy: Redetermination and Redeeming,” available online at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.4596471630.

Special Enrollment Period for Individuals Losing LIS in 2007

Individuals who lost their Low Income Subsidy eligibility as of January 1, 2007, as a result of the LIS re-determination process, may still have a Special Enrollment Period (SEP) in which to switch plans. CMS has revised the timing of this SEP, which was originally set to end on March 31, 2007. In its new form, the SEP lasts from January 1 to March 31 of each calendar year, OR starts the month the beneficiary is notified of the

loss of LIS eligibility and continues for two months after, whichever occurs later in the calendar year. For example, beneficiaries who receive notices in February 2007 indicating that their LIS eligibility will end effective March 1, 2007 will have the opportunity to make one enrollment election (i.e. to either enroll in a new plan, or to disenroll from Part D) from February 1, 2007 to April 30, 2007.

D. MEDICARE ADVANTAGE PLANS

Since the implementation of the Medicare Part D prescription drug benefit, the number of Medicare Advantage plans on the market has exploded. Congress created the Medicare Advantage program (MA, also known as Medicare Part C, formerly titled Medicare+Choice) more than ten years ago as a vehicle for private alternatives to original, fee-for-service Medicare. The Medicare Modernization Act (MMA), which created Part D, also authorized MA plans to offer Part D prescription drug benefits. These plans are known as MA-PDs. Medicare recipients considering MA plans are faced with a number of complicated alternatives:

- Medicare **health maintenance organizations** (HMOs), which offer traditional managed care in a closed provider network;
- **Preferred provider organizations** (PPOs), which allow enrollees to see out-of-network providers, usually at increased cost;
- **Private fee-for-service** (PFFS) plans, which usually allow enrollees to see any provider who agrees to the plan's terms and conditions;
- **Medicare savings accounts** (MSAs), high deductible health plans, usually inappropriate for very low-income clients; and
- **Special needs plans** (SNPs), coordinated care plans that restrict enrollment to certain categories of "special needs" individuals, such as the chronically ill or those dually eligible for Medicare and Medicaid.

Private Fee-for-Service Plans

Since implementation of the MMA (which increased the amount of money the federal government pays to reimburse MA providers), PFFS plans in particular have grown at a staggering rate. Between December 2005 and February 2007, PFFS enrollment increased from nearly 209,000 to 1.3 million enrollees, an increase of over 500%. See Kaiser Family Foundation Fact Sheet, Medicare Advantage (Feb. 2007). Unlike most other MA plans, PFFS plans are not required to establish provider networks or to coordinate care. Instead, enrollees may go to any doctor if that doctor agrees to accept the plan's terms and conditions. Providers may decide before every visit whether or not to accept PFFS coverage. Reports from around the country indicate that many providers are choosing not to accept patients enrolled in PFFS plans. Some doctors and hospitals refuse to accept PFFS coverage due to problems getting paid, or because doing so could make working with specialists more difficult. For PFFS enrollees, this results in unanticipated disruptions in care. The problem is especially acute in rural areas, where provider options are limited.

Abusive and Deceptive Marketing

Outraged advocates and beneficiaries across the country have reported numerous egregious incidents of fraudulent and abusive marketing and sales techniques by Medicare Advantage agents and representatives. According to a report by California Health Advocates (CHA) and the Medicare Rights Center (MRC), low-income clients in particular are at risk for abusive and deceptive marketing of inappropriate health insurance products. Improper tactics include aggressive marketing, including high-pressure, illegal door-to-door sales; “bait-and-switch” tactics in which beneficiaries believe they are only signing up for a Medigap or stand-alone PDP; and agents who falsely present themselves as representatives of Medicare or the state. Dual-eligible seniors are particular targets because they have a right to change plans any time during the year, outside the annual enrollment period.

Agents may also steer beneficiaries into inappropriate MA plans, either in a deliberate effort to mislead or because the agents themselves do not understand the complicated issues involved. For instance, PFFS agents have suggested that enrollees may see “any” doctor they choose, without explaining that doctors may refuse to accept PFFS terms and conditions. Marketing materials sometimes tout purported “additional benefits” that are already covered under a state Medicaid program.

Unfortunately, brokers and sales agents have a strong incentive to increase enrollments because they typically earn larger commissions for MA plans than for stand-alone prescription drug plans (PDPs). Agents continue to target senior residences, adult day health centers, senior centers and other locations where they are likely to maximize enrollment (and commissions).

Non-dual eligible consumers who are victims of MA plan marketing abuses and who don’t have any other SEP may be able to get back into original Medicare by requesting a SEP based on “contract violations by a plan sponsor” from CMS. The individual must demonstrate that the sponsor made a material misrepresentation in its marketing. For more details, see NSCLC’s tool enrollment tool, available online at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.4596471630/area_folder.2006-10-31.1884975563. If CMS denies the request, however, the enrollee will have to wait until the next open enrollment period.

☞ The CHA/MRC report, “After the Goldrush: The Marketing of Medicare Advantage and Part D Plans; Regulatory Oversight of Insurance Companies and Agents Inadequate to Protect Medicare Beneficiaries,” is available online at http://www.cahealthadvocates.org/_pdf/advocacy/2007/CHA-MRC-Brief-AfterTheGoldrush-2007-01.pdf.

If you encounter suspected marketing abuses involving MA plans, file a complaint with CMS. Contact information for CMS regional offices is available online at <http://www.cms.hhs.gov/partnerships/downloads/PartDComplaints.pdf>. To share stories of marketing misconduct with advocates who are working on the issue, please contact Families USA, MRC, or CHA. A sample complaint filed by Bay Area Legal Aid against a WellCare Medicare Advantage plan's marketing practices in Alameda County is available online at www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2022247391.

Open and Special Enrollment Periods for Medicare Advantage Plans

The Open Enrollment Period (OEP) during which Medicare beneficiaries can make one election, or change in Medicare Advantage plans, ends on March 31, 2007. Beneficiaries can use the OEP to: 1) switch from a Medicare Advantage prescription drug plan (MA-PD) to another MA-PD or original Medicare with a Prescription Drug Plan (PDP); 2) switch from one MA-only plan (no prescription drug coverage) to another MA-only plan or original Medicare with no drug coverage; 3) switch from original Medicare with a PDP to a MA-PD; or 4) switch from original Medicare with no drug coverage to a MA-only plan. (For a useful, easy-to-read visual representation of these options, go to the Health Assistance Partnership's chart at www.hapnetwork.org/assets/pdfs/2007-MA-OEP-chart.pdf.)

An OEP cannot be used to enroll in prescription drug coverage for the first time or to drop prescription drug coverage entirely; it also cannot be used to switch from one (non-Medicare Advantage) prescription drug plan to another (non-Medicare Advantage) prescription drug plan (in other words, someone cannot use the OEP to switch from a PDP to another PDP). During an OEP, MA plans have the option of accepting new enrollment elections but are not required to do so. If an MA plan accepts any enrollments during an OEP, however, it must accept all enrollments into the plan.

Dual eligibles have a continuous Special Enrollment Period (SEP) that allows them to switch into or out of Medicare Advantage plans (including plans with Part D coverage) at anytime.

Controversial Limited Open Enrollment Period for MA-Only Plans

In late 2006, the outgoing Congress created a new Medicare Advantage (MA) related enrollment period for Medicare beneficiaries. This new enrollment period allows individuals in the original, fee-for-service Medicare program one opportunity during the year in 2007 and 2008 to enroll in a Medicare Advantage-only plan (meaning any MA plan without Part D coverage). On February 7, 2007, CMS issued a memo to all Medicare Advantage Organizations describing this new enrollment period, which has been named the "Limited Open Enrollment Period" or "L-OEP."

Advocates should caution clients enrolled in Medicare Part D that joining an MA-only plan during the L-OEP can cause loss of their prescription drug coverage. According to CMS' interpretation of the authorizing legislation, if a beneficiary in original Medicare with a PDP chooses to enroll in an MA-only HMO, PPO or Regional PPO, "his or her enrollment in the PDP will be automatically cancelled as of the effective date of enrollment in the MA-only plan." Medicare enrollees with a stand-alone PDP will lose their Part D coverage altogether if they enroll in an MA-only HMO, PPO or Regional PPO.

While CMS has established certain procedures that MA plans must follow if an applicant is identified as being in danger of losing his/her PDP coverage, including contacting the individual to "ensure that s/he understands" that such an enrollment could jeopardize their prescription drug coverage, CMS notes that such contact "may be made by telephone, written notice, or both." Given that plans can meet this obligation through a phone call only, and in light of advocates' experiences with some MA and Part D plans' failure to communicate effectively with their enrollees, advocates fear that these safeguards will not be enough to protect beneficiaries from and inform them about the potential loss of drug coverage.

Recognizing that this is dangerous to Medicare beneficiaries, several advocacy groups, including NSCLC, signed on to a letter to CMS drafted by California Health Advocates (CHA) arguing that CMS is misinterpreting Medicare law with respect to elections permitted under the L-OEP. In a letter dated, March 8, 2007, CMS rejected the advocates' arguments, and stated "we have retained the existing process by which an individual enrolled in a PDP who elects enrollment in an MA coordinated care plan [HMO, PPO] will be automatically disenrolled from the PDP." They note that "[p]lans may not enroll individuals who do not confirm their understanding of the consequences of their choice... [and] as an added safeguard, CMS will establish a special enrollment period (SEP), available on a case-by-case basis, to allow individuals to return to their PDP if, despite the required confirmation process, they subsequently indicate that they were unaware that they would lose their prescription drug coverage as a result of their L-OEP election."

Note that if someone in original Medicare and a PDP enrolls in an MA-only Private Fee-for-Service (PFFS) plan, she or he will be able to keep Part D coverage (although, as explained above, enrollment in a PFFS plan may limit access to providers). Since the L-OEP applies when no other enrollment period is in effect, it will begin for most people starting April 1st. It does not affect dual eligibles who have a continuous SEP that allows them to switch into or out of Medicare Advantage plans (including plans with Part D coverage) at anytime.

☞ For a copy of CMS' February 7 memo on the L-OEP, go to http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2240438420. For a copy of the advocates' letter

and the response from CMS, visit www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2022247391.

Portions of this article were taken from the CHA/NSCLC California Low-Income Health Advocate Alert on Medicare Part D.

E. PREMIUM WITHHOLD PROBLEMS

Problems associated with incorrect withholding of Part D or Medicare Advantage premiums from Social Security payments, reported in the December National Alert, have continued in 2007. CMS and SSA system errors caused incorrect withholding for some people who signed up for automatic withholding of premiums from their Social Security payments. In January 2007, CMS announced that it had compared records with the SSA and found 200,000 Medicare beneficiaries with automatic withholding problems. Some beneficiaries are being charged now by plans because too little was withheld, or premiums were never withheld. Other beneficiaries had too much withheld and are now due a refund. In some cases, beneficiaries have received 1099 tax forms reporting that they received a refund, but have yet to see a check. In other cases, beneficiaries have been told that additional premiums are being withheld, but their plans have no record of receiving the extra money.

CMS sent letters to 117,000 beneficiaries nationwide explaining that their requests for premium withholding were incorrectly processed. The letters either informed recipients that an amount owed will be withheld from their February 2007 Social Security payment, or informed them that they are entitled to a refund. Unfortunately, the letters may cause further confusion and anxiety. They fail to inform recipients about exact amounts allegedly owed, options for setting up payment plans, or how to dispute the accuracy of CMS' records. Copies of the letters and additional information are available on CMS' website at <http://www.cms.hhs.gov/Partnerships/CurrentMailings.asp>.

According to CMS, an additional 80,000 beneficiaries have also experienced unresolved premium problems, but were not sent letters in February. Instead, this group will be placed into a "reconciliation process" conducted by CMS. CMS says that it expects this process to occur in the spring of 2007, and it will decide then how to recoup amounts owed or issue refunds for the remaining affected beneficiaries. The beneficiaries subject to later reconciliation have not yet received any notice.

CMS officials have confirmed that the government requires plans to bill enrollees for unpaid premiums; plans are generally not allowed to forgive premiums owed. (It remains to be seen how aggressively plans will attempt to collect past due premiums.) A beneficiary who believes that a Part D plan is erroneously attempting to recoup premium fees, or that premiums were wrongfully deducted from a February Social Security payment, should verify the amount charged or deducted and compare it to his or her records and any 1099 form. If a discrepancy exists, the beneficiary or an advocate should

file a complaint with CMS. Beneficiaries should be warned, however, that it may take a very long time to fix—one advocate was told by CMS staff that it could take up to one year for her client’s premium problem to be resolved.

In situations where a dual eligible individual was erroneously enrolled in an enhanced plan, and is now being charged for an under-withheld portion of the premium attributable to the “enhanced” benefit, some advocates have successfully obtained retroactive enrollment into a basic plan offered by the same Part D plan sponsor. CMS must approve any request for retroactive enrollment. Advocates should contact their regional CMS office to request retroactive enrollment.

F. EMERGENCY DRUG PLANS

Despite efforts by advocates to work with state governments, some backup systems for dual eligible Part D enrollees have been cancelled or restricted since January 31, 2007. Without an adequate safety net in place, dual eligibles who continue to have problems at the pharmacy counter may be sent home empty handed.

II. PART D NEWS & VIEWS

A. LITIGATION UPDATE: *SITU* v. LEAVITT

Plaintiffs recently won two major procedural victories in *Situ v. Leavitt*, a lawsuit filed by NSCLC and the Center for Medicare Advocacy on behalf dual eligible Medicare beneficiaries against the federal government for its failure to protect Medicaid beneficiaries in the Medicare prescription drug program. On December 18, 2006, the court issued an order largely denying the government’s motion to dismiss, 2006 WL 3734373 (N.D. Ca. Dec. 18, 2006), and on January 12, 2007 it certified a nation-wide class, ___ F.R.D. ___, 2007 WL 127993 (N.D. Ca. Jan. 12, 2007).

The Centers for Medicare and Medicaid Services (CMS) contended that the court had no jurisdiction to hear the case and that the numerous problems cited by the plaintiffs were not attributable to the federal government, but rather, to a particular private plan, a state, a pharmacist, or the plaintiffs themselves. The court rejected most of the government’s arguments, upholding the right of eight of the individual plaintiffs to proceed and to prove their claims. The judge did rule, however, that dual eligible beneficiaries had to contact CMS, a plan or a state in order to meet the jurisdictional “presentment” requirement.

In a separate decision, the court certified a nationwide class, holding that the plaintiffs had met each of the requirements for a class action set forth in Federal Rule of Civil Procedure 23. The Court modified the proposed class definition somewhat to refer to specific conduct of the defendant. The class is now defined as:

All full benefit dually eligible Medicare beneficiaries who have not received the full benefits of Medicare Part D prescription drug coverage or The Low Income Subsidy because of one or more of the following: (1) the Secretary did not follow all auto-enrollment requirements after the beneficiary failed to enroll in a plan of his or her choice; and (2) at the time benefits were sought, the beneficiary's Part D plan had not been informed by the Secretary of the beneficiary's enrollment in the plan or his or her entitlement to the Low Income Subsidy; or (3) the beneficiary was listed by the Secretary as a member of more than one Part D plan or as a member of the incorrect Part D plan after the beneficiary elected to change plans.

☞ Copies of these court's orders are available on NSCLC's website at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2785097150. Questions about the case can be directed to Jeanne Finberg at NSCLC, (510) 663-1055, ext. 305.

B. LEGISLATION AND OVERSIGHT

The newly elected Congress appears ready to take on some Medicare Part D issues. Although a complete overhaul of the program seems unlikely, some reform may be on the horizon. In the House, Congressman Lloyd Doggett introduced H.R. 1536, the "Prescription Coverage Now Act of 2007," on March 15 to amend the Medicare Modernization Act (MMA) to expand eligibility and participation in the Low Income Subsidy, and to provide additional protections for LIS recipients. NSCLC's website contains a summary and link to the bill's status at <http://www.nsclc.org/areas/medicare-part-d/>.

Other changes to the MMA are under consideration. In the Senate, four bills are being contemplated which would address the coverage gap (the doughnut hole), zero co-payments for certain people in the community, and Low Income Subsidy issues. The House passed a bill allowing the government to negotiate drug prices in Part D. The President has already indicated, however, that he will veto the bill.

Several legislative leaders, including key members of the California delegation (Representative Waxman and Representative Stark), have expressed an interest in increasing the accountability of CMS and SSA regarding the Part D benefit. Hearings are expected soon. Advocates can help by continuing to share problems, stories and information, as well as identifying potential witnesses who might be able to testify.

C. SURVEY FINDS PLANS FAIL TO PROVIDE LANGUAGE ACCESS

A new survey of California Part D plans conducted by NSCLC and partner organizations reveals that the call centers of the Medicare Prescription Drug Plans that serve low

income beneficiaries are not meeting their obligation to serve Limited English Proficient (LEP) beneficiaries. CMS, the federal agency that administers the Medicare program, requires Medicare plan call centers to serve beneficiaries that do not speak English. There are many LEP Medicare beneficiaries across the country.

According to the report, “benchmark” plans (plans into which dual eligibles are automatically enrolled) in California are only able to serve LEP dual eligible beneficiaries in their primary language 55% of the time. Non-Spanish speaking LEP beneficiaries have even less success communicating with their plans. Plan sponsors are only able to serve non-Spanish speaking LEP dual eligible beneficiaries in their primary language 37% of the time. While the study focused on California, most of the plans surveyed are large plans which operate nationally.

Plan customer service representatives failed to connect survey callers to someone speaking their language for a variety of reasons. Unsuccessful calls were most often the result of the representative’s inability either to recognize that the caller was speaking a language other than English, or to identify the language being spoken. There were, however, also calls during which the representative correctly identified the language spoken, but still made no attempt to connect the caller to an interpreter. Many representatives told callers that they must speak English if they wanted assistance.

Even calls that successfully connected to an interpreter speaking the appropriate language did not always result in a successful exchange of information. While interpreters were generally linguistically competent, they were not always familiar with health systems concepts and terminology, nor did they always meet professional interpretation standards requiring complete, undistorted, and accurate transmission of communications.

The survey also revealed that translated materials are not available to LEP beneficiaries. No one was able to obtain written information in a language other than English.

The report recommends that plans develop detailed and comprehensive strategies for providing services to LEP individuals; provide in depth customer service and language assistance training to all plan staff that interact with beneficiaries; monitor contracted and in-house interpreters; and develop and distribute written translated materials.

The report also recommends that CMS: 1) strengthen, clarify, monitor and enforce all existing cultural and linguistic requirements imposed on Medicare Part D plans; 2) require plans to create and share with CMS comprehensive and detailed strategies for serving LEP beneficiaries; and 3) ensure that written materials are available in key languages.

☞ For more details, the entire report is online at <http://www.nsclc.org/areas/medicare-part-d>. Questions about the report or language access and the Medicare prescription drug

program can be directed to Katharine Hsiao, khsiao@nsclc.org, or Kevin Prindiville, kprindiville@nsclc.org.

III. ADDITIONAL RESOURCES FOR ADVOCATES

A. CMS MATERIALS

CMS recently released information on a number of topics that may be useful for advocates:

1. Final and Revised Guidance Published

CMS released final chapters of the Medicare Prescription Drug Manual: Chapter 5 – Benefits and Beneficiary Protections; Chapter 6 – Part D Drugs and Formulary Requirements; and Chapter 14 – Coordination of Benefits. A revised version of chapter 18 of the Medicare Prescription Drug Manual. “Chapter 18 – Part D Enrollee Grievances, Coverage Determinations, and Appeals,” has also been published. The documents are available at http://www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp.

2. Questions & Answers about Part D and Vaccines

In early December, CMS released a Q&A on Part D and vaccines. The Q&A is available at <http://www.ascp.com/medicarerx/upload/QACombinedVaccines12106.pdf>, and explains alternatives for obtaining Part D-covered vaccines at physicians’ offices. Reports from advocates indicate, however, that some doctors are unaware, unwilling or unable to bill Part D plans for covered vaccines.

3. CMS Memo on DESI Drugs and Oral Anti-Cancer Agents

As of February 1, 2007, CMS has a new policy that excludes less than effective (LTE) drug efficacy study implementation (DESI) drugs from coverage by Medicare Part D. LTE DESI drugs are those that have not been proven both safe and effective, but which the FDA permits to remain on the market because they were introduced prior to 1962 amendments to the federal Food, Drug and Cosmetic Act which tightened regulation of drugs sold in the United States. Plans were supposed to provide beneficiaries who have been taking LTE DESI drugs with a transition supply in January, 2007, to allow beneficiaries time to switch to covered Part D drugs.

In the same memo, CMS clarified that oral anti-cancer drugs with no purpose other than cancer treatment (e.g., capecitabine) are not eligible for reimbursement under Part D. These oral anti-cancer drugs may only be covered under Medicare Part B.

CMS' memo on LTE DESI drugs and oral anti-cancer drugs is available online at http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/QADESICancer_12.05.06.pdf.

4. CMS Enrollment Data Website

CMS recently released updated Medicare Part D enrollment data, available online at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp. According to the data, there are currently 23.9 million individuals enrolled in a Medicare Prescription Drug Plan. Of these, 17.25 million are enrolled in a stand-alone Prescription Drug Plan (PDP) and 6.65 million are enrolled in a Medicare Advantage Prescription Drug (MA-PD) plan.

There are currently 9.18 million beneficiaries receiving the Low Income Subsidy. Most of these (6.88 million) were deemed eligible for the subsidy because they receive some form of Medicaid or are SSI recipients. The remainder (2.3 million) applied for the subsidy and were determined eligible by the Social Security Administration. There are still an estimated 3.27 million beneficiaries who are eligible for the Low Income Subsidy but do not yet receive it.

CMS indicates that about 2.4 million Medicare Part D enrollees switched plans during the Annual Enrollment Period last Fall (representing 10% of all enrollees). Close to half of those who changed plan (1.17 million) were Low Income Subsidy recipients who were automatically reassigned to a new plan so that they would not have to pay increased premiums. In a tracking survey conducted by CMS, only 34% of the seniors surveyed reported comparing plans during the Annual Enrollment Period. An even smaller proportion of those surveyed (“over half” of the 34 percent who compared plans) appeared to have made a “thorough” comparison of their options, which CMS defined to mean consideration of premium, deductible or co-pays, and coverage.

5. Address for Filing an Appointment of Representative Form

Advocates who are interested in getting an appointment of representation form filed with CMS may want to try mailing a copy of the Appointment of Representative form, (certified mail) to “General Correspondence, Palmetto GBA, PO Box 100297, Columbia, SC 29202-3927.” If the form is properly filed, you and the beneficiary you are representing will receive a notice acknowledging receipt of the form and stating that you have the authority to access the beneficiary’s Medicare records. The authorization should stay in place until the beneficiary asks that it be terminated.

B. NATIONAL ADVOCACY MATERIALS

1. National Part D Conference Calls

The National Senior Citizens Law Center and the Center for Medicare Advocacy sponsor monthly conference calls for legal services attorneys or other low income advocates nationwide to discuss Medicare Part D. If you would like to participate, contact Jeanne Finberg of the National Senior Citizens Law Center at (510) 663-1055, ext. 305, or Vicki Gottlich or Patricia Nemore of the Center for Medicare Advocacy at vgottlich@medicareadvocacy.org, pnemore@medicareadvocacy.org or (202) 216-0028.

2. National Alert

To receive this Alert, or to obtain alternative formatting, please contact Nina Talley-Kalokoh, ntk@nsclc.org or (510) 663-1055, ext. 301, and ask to be put on the National Alert email list. Alternatively, look for this and future Alerts by checking our website at <http://www.nsclc.org/areas/medicare-part-d>.

3. National Senior Citizens Law Center Tools

NSCLC has developed a number of materials and tools for advocates representing low income elderly or people with disabilities. These are available for free on our website at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.4596471630. New and recently updated tools include:

- “2007 Medicare Part D Dollar Amounts: Deductibles, Coverage Limits, TrOOP, Co-Pays, Low Income Subsidy, Late Enrollment and Amount in Controversy” (Feb. 2007);
- “The Low Income Subsidy for Medicare Part D Enrollees: Summary of Regulations and Procedures” (Feb. 2007);
- “Overview of CMS Guidance on Eligibility, Enrollment and Disenrollment” (Jan. 2007); and
- “Advocate’s Guide to Solving Problems Under Part D: Assisting Low Income Beneficiaries in the Early Months of 2007” (Jan. 2007).

New materials from NSCLC also outline some of the flaws in the Part D program that impact dual eligibles and propose actions that CMS, Congress and the Administration can take to fix the flaws. These “Flaws and Fixes” are available online at, http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2007-01-31.8062582475.

4. National Websites

Information about Medicare Part D is posted on the NSCLC website, <http://www.nsclc.org/areas/medicare-part-d>. Other helpful websites include: Center for Medicare Advocacy at www.medicareadvocacy.org; Families USA at www.familiesusa.org; Medicare Rights Center at www.medicarerights.org; Health Assistance Partnership at www.healthassistancepartnership.org; and Kaiser Family Foundation at www.kff.org/medicare.

5. Other New Reports and Information

In addition to materials mentioned elsewhere in this Alert, advocates may find the following reports and tip sheets particularly useful and/or informative:

- The Center for Medicare Advocacy has prepared a summary of transition supply requirements, http://www.medicareadvocacy.org/PartD_07_01.04.Transition.htm.
- Health Assistance Partnership (HAP) has created a list of important information to share with pharmacists when beneficiaries face barriers to accessing their medications, <http://www.hapnetwork.org/medicare-drug-coverage/helpful-info-for-rph.html>.
- HAP also has prepared information to assist advocates and beneficiaries in applying for retroactive disenrollments, online at <http://www.hapnetwork.org/conference-calls/medicarecc032107.html>.
- A new report from Consumers Union demonstrates that plans often raise the prices beneficiaries pay for their Part D drugs. The report is available online at www.consumersunion.org/pub/campaignprescriptionforchange/004278.html.
- The Kaiser Family Foundation has updated its “Health Plan Tracker” which provides local, regional and national information about Medicare Advantage and Medicare Prescription Drug Plans. The “Health Plan Tracker” is available at www.kff.org/medicare/healthplantracker.

Reporting Problems to CMS

Reporting problems with Medicare Part D provides CMS with important feedback about how this new program is affecting beneficiaries on the ground. Many issues involving access to medication may be resolved by contacting the plan or calling the 1-800-MEDICARE number. Individuals and advocates should also contact the CMS regional office to report problems; we recommend an email or a letter to establish a written record of the complaint. For CMS regional contact information, go to “Medicare Part D for Low Income Advocates: The Basics” at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.4596471630.

Your Stories Are Needed

In order to help to get changes at the state and federal levels, we need to hear about the problems your low income clients are facing. We know that your time as advocates is already stretched thin, but any time you can take to report client stories would be extremely helpful.

NSCLC has an updated “**Client Story Form**” to report problems your clients have faced. You can access the new form at www.nslc.org/areas/medicare-part-d. We are particularly interested in reports of LIS delays. Thank you for sharing your stories and information.

Do you have questions about Medicare Part D? Topics you’d like to see covered in future National Alerts? Tips or experiences with Medicare Part D that you’d like to share with advocates in other states? Please send all questions, comments and feedback to the National Senior Citizens Law Center attorneys, listed below.

Jeanne Finberg, Directing Attorney, (510) 663-1055 ext. 305

Katharine Hsiao, Staff Attorney, (510) 663-1055 ext. 306 or khsiao@nslc.org

Georgia Burke, Project Attorney, (510) 663-1055 ext. 304 or gburke@nslc.org

Kevin Prindiville, Project Attorney, (510) 663-1055 ext. 307 or kprindiville@nslc.org

Anna Rich, Project Attorney, (510) 663-1055 ext. 303 or arich@nslc.org