



March 2008

Low-Income Advocate Alert On Medicare Part D

Highlights of this Issue

- CMS clarifies formulary guidance on **prior authorization requirements**, conversion to **over-the-counter status**, and **off-label use**. Page 2.
- 76,000 Low Income Subsidy (LIS) recipients will receive **LIS termination notices** from the Social Security Administration. Page 4
- CMS suspends enrollment and marketing into **Health Net Orange** plans. Page 5.
- Information about Part D plans' obligations to **reimburse incorrect cost-sharing**. Page 6.
- News specifically for **California advocates**, including information about Kaiser's Special Needs Plan for dual eligibles, Medi-Cal coding errors, and an NSCLC guide on Part D transition drug supply policies. Page 8.
- CMS' **proposed benchmark plan regulation** and advocates' views. Page 10.
- CMS memo to Part D plans about providing adequate call center **language access** for limited-English proficient Medicare beneficiaries. Page 12.

This Alert contains both California-specific and national information for advocates.

**To receive this Alert in alternative formatting,
call (510) 663-1055 x. 301.**

IMPORTANT INFORMATION

PLAN CHANGES FOR 2008

- **Numbers Show that Medicare Part D Enrollees Are Not Changing Plans – Even when Costs Rise**

At the end of January, the Centers for Medicare and Medicaid Services (CMS) released information about actions Medicare beneficiaries took during the 2007 Annual Enrollment Period (AEP). The data showed that remarkably few Medicare beneficiaries took advantage of the opportunity provided by the AEP to change plans. Only 3.1 million Part D enrollees (12%) changed plans during the AEP. Of these, 2.1 million were Low Income Subsidy (LIS) recipients whom CMS moved to a new organization to protect them from paying premiums in 2008. Only 6% of non-LIS recipients changed plans.

CMS' data are particularly striking in light of the Kaiser Family Foundation's November 2007 finding that 75% of Part D enrollees would face higher premiums if they did not switch to a less expensive plan.¹ Nearly 20% of enrollees were facing monthly premium increases of \$10 or more according to Kaiser. Of course, monthly premiums are not the only aspect of Part D plans that change from one year to the next: plans also change co-payments, formularies and rules for accessing drugs on the formulary.

CMS CLARIFIES MEDICARE PART D FORMULARY GUIDANCE

CMS recently released a guidance letter "clarifying" several formulary issues for insurance plans providing prescription drug coverage under Medicare Part D. The guidance letter is generally helpful to beneficiaries. Three major areas were discussed:

- **Changes in Prior Authorization Requirements**

Plans may not make their prior authorization criteria for prescription drugs more restrictive during a plan contract year without direct CMS approval.² CMS expects that such changes would be rare, e.g., when the FDA adds a black box warning for a product.

- **Conversion to OTC Status**

When a drug changes from a legend drug (prescription-only) to an over-the-counter (OTC) drug, existing inventories of the prescription drug are covered by Part D. The newly approved OTC version of the drug is not covered by Part D.

¹ Online at <http://www.kff.org/medicare/7706.cfm>.

² The CMS letter, which was issued February 1, 2008, is available on NSCLC's website at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2240438420.

Dropping legend drugs from a formulary mid-year because of OTC conversion is permitted; however, if a plan drops a legend drug from its formulary because of conversion to OTC, the plan must still satisfy the two drugs per category and class requirement found in CMS's formulary guidance. This means that in some cases, a plan will need to add a new drug to its formulary when removing a drug that has become OTC.

Plans must notify affected beneficiaries at least 60 days prior to a drug being dropped from a formulary but CMS strongly recommends that plans provide prospective notice as soon as the OTC conversion is announced by FDA.

Sponsors cannot add or modify step therapy protocols mid-year because of an OTC conversion. However, sponsors are permitted to make newly transitioned OTC products available through their broader utilization management program at no cost to their enrollees. *Note:* OTC drugs are not covered as part of the standard Part D benefit; however, CMS permits plans to offer certain OTC drugs at zero cost as part of their administrative cost if it is more cost-effective for the plan to offer the OTC drug than to cover its legend counterpart.

- **Off-Label Use**

Part D coverage of prescription drugs for off-label use is permitted only when there is a showing that the drug is both medically necessary for the beneficiary and used for a “medically accepted indication,” i.e., that the prescription is for an off-label use that appears in one of three commercial compendia referenced in the governing statute. CMS is aware that, because a diagnosis is not usually included with a prescription, there may be circumstances when a plan has covered a beneficiary's use of a drug and later discovers that the usage apparently is not for a “medically accepted indication.” In such situations, the CMS guidance provides:

- Plans should not attempt to recover payments from pharmacies or enrollees.
- Plans must send notice of coverage determination decisions to affected enrollees. The notice must include the name of the affected covered Part D drug; the reason why the sponsor is no longer covering the drug; alternate drugs on the plan formulary, and expected cost-sharing for those drugs; and the enrollee's right to a redetermination.
- CMS expects plans “to consider the enrollee's health situation, and continue to cover the drug to the extent it determines that doing so is necessary to avoid risk to the enrollee's health while providing for a transition to another form of treatment.” *Note:* This is the first time that CMS has stated clearly in writing that a negative coverage determination based on a decision that a drug is not for a medically accepted indication requires that plans continue to supply drugs during a transition to another treatment.

CMS intends to incorporate its contents into its next revision of Chapter 6 of the Prescription Drug Benefit Manual. For further information, contact Georgia Burke, gburke@nsclc.org.

76,000 BENEFICIARIES RECEIVE LIS TERMINATION NOTICES; NEED TO TAKE ACTION TO RETAIN BENEFITS

During the first week of March, the Social Security Administration began mailing Low Income Subsidy termination notices to beneficiaries who did not provide SSA with information it requested to determine continued eligibility for the LIS. Beneficiaries who do not act immediately will lose their LIS effective April 1, 2008.

In fall 2007, as part of its formal redetermination process, SSA began contacting some LIS recipients requesting information about changes in income, assets or household size. The process, which was completed in February, involved notices sent by SSA and several follow up phone calls from SSA to beneficiaries selected for redetermination. SSA reports that approximately 80,000 beneficiaries responded to these contacts. The remaining 76,000 who did not respond will receive the termination notice. Email Anna Rich, arich@nsclc.org, for a breakdown of how many beneficiaries in your state will receive the termination notice.

Beneficiaries who received the notice can still take action to preserve their subsidy. Beneficiaries can:

1. **Appeal the determination.** Beneficiaries who believe they are still eligible for the LIS have 60 days from the day they receive the notice to file an appeal with SSA. Beneficiaries who file the appeal within 10 days of receiving the notice will continue to receive the benefits of the LIS until the appeal is decided, whether or not the appeal is ultimately decided in their favor. Unless they can show good cause, beneficiaries who file their appeal more than 10 days after receiving the notice will not receive the LIS benefits while the appeal is pending. Beneficiaries can file an appeal by calling SSA (1-800-SSA-1213; 1-800-772-1213).
2. **Reapply for the subsidy.** Beneficiaries who are not currently eligible for the subsidy can reapply if circumstances change and they think they may be eligible again. Beneficiaries who do not appeal must wait until April 1 to reapply. Applications can be filed on-line (www.ssa.gov/prescriptionhelp/) or by calling SSA at the number above.

Beneficiaries whose LIS is terminated are provided a three month Special Enrollment Period (SEP) during which they can switch plans. The SEP will begin on April 1, 2008 and end when they change plans or on June 30, 2008, whichever date is earlier. These beneficiaries will also receive a notice from their current Part D plan informing them of the monthly premium they will have to pay if they remain in the plan.

Thanks to the Center for Medicare Advocacy for contributing to this article.

PLANS IMPOSE DOLLAR LIMITS AS UTILIZATION MANAGEMENT TOOLS

Beneficiaries have reported that pharmacists sometimes receive a “Dollar Amount Exceeded” message when processing some Part D prescriptions. On investigation, advocates have learned the many, if not all, plans, use this as an across-the-board edit when a single claim exceeds a dollar amount set by the plan (usually between \$1,500 and \$2,000). It usually can be overridden if the pharmacist calls the benefits manager and confirms that the prescription is not in error. In some cases, it has been possible to get a permanent override so the problem does not appear on the next refill. In other cases, plan representatives have stated that pharmacists must call in each time to obtain an override.

Advocates have been told by CMS staff that the agency encourages plans to impose administrative edits to protect against prescribing errors or fraud but that plans are not required to submit such edits to CMS for review or approval. These procedures contrast with prior authorization and other utilization management requirements where CMS must approve the requirement and where beneficiaries have exception and appeals rights available if the requirements result in denial of needed medications.

Advocates have multiple concerns about the edit. Pharmacists may not know that an override is possible. In addition, there is concern that beneficiaries have no knowledge of the existence of these edits. They do not appear in a plan’s formulary or on CMS’s plan finder. Beneficiary rights are undefined.

Advocates with clients who have had problems with this edit should file a complaint. Please also tell NSCLC by contacting Georgia Burke, gburke@nsclc.org.

HEALTH NET ORANGE ENROLLMENTS SUSPENDED

In a rare disciplinary action, CMS suspended all new enrollments and marketing for Health Net’s stand-alone prescription drug plans, Health Net Orange Option 1 and Option 2, as of January 16, 2008. CMS took this enforcement action against Health Net due to “multiple enrollment processing violations” and an incorrect annual notice of change.³ No further details about the violations are available.

Advocates reported that many clients who intended to enroll in Health Net Orange prior to January 16 discovered when they reached the pharmacy counter that their enrollment was delayed. Pharmacists who are able to bill the enrollee’s old 2007 plan should be encouraged to do so. Otherwise affected beneficiaries may have to pay out-of-pocket or file complaints with Health Net and CMS.

³ A list of CMS enforcement actions through January 2008 can be seen here: http://www.cms.hhs.gov/MCRAAdvPArDENrolData/Downloads/Enforcement_Actions_Web.pdf.

Beneficiaries' whose access to coverage has been disrupted due to problems at Health Net Orange may wish to ask CMS for a special enrollment period (SEP) on the basis of CMS' sanction. Such SEPs are determined by CMS on a case-by-case basis and depend on the client's particular circumstances; according to CMS guidance, this SEP will usually apply when the reason for the sanction (here, enrollment processing problems and an incorrect ANOC) affected the beneficiary. *See* CMS PDP Enrollment Guidance § 20.3.8(2).

PART D PLAN REIMBURSEMENTS FOR INCORRECT COST-SHARING

As Part D advocates know, the Medicare Part D enrollment and Low Income Subsidy processes are filled with systemic delays that often result in gaps between the date when a beneficiary becomes entitled to the Low Income Subsidy and the date when the beneficiary is actually able to access his or her medications with the correct cost-sharing level at the pharmacy counter.⁴ For beneficiaries who cannot pay out of pocket for medication during this gap, the only alternative may be to attempt to present "best available evidence" of subsidy eligibility to the plan.⁵

For those enrollees who either pay out of pocket for the entire cost of their medication during the gap or pay a higher level of cost-sharing than their LIS level entitles them, plans are required later to reimburse them by refunding any improperly collected cost-sharing. 42 C.F.R. § 423.800(c). Unfortunately, CMS has not provided further substantive regulation or guidance about how and under what timeframes plans should reimburse amounts owed. Instead, CMS guidance allows plans to develop their own "standard operating procedures" for cost-sharing reimbursements.⁶ In follow-up communications with advocates at the Medicare Rights Center (MRC), CMS confirmed that Part D plans have an affirmative obligation to provide reimbursements, and should not simply wait for a request for reimbursement (with exceptions such as when the beneficiary lives in a long-term care institution and the long-term care pharmacy likely holds receivables).

Unfortunately, many advocates have had difficulty getting timely and full reimbursements from plans, and suspect that Part D plans are not meeting their affirmative obligations to provide reimbursements. Advocates who have experienced problems getting reimbursements from plans are invited to share their stories with Kim Glaun at MRC, kglaun@medicarerights.org, or Jackie Cheney, jcheney@medicarerights.org.

⁴ The National Senior Citizens Law Center recently provided an online training for advocates on data transfers and delays that may be offered again in the future; please contact Anna Rich, arich@nsclc.org, or Kevin Prindiville, kprindiville@nsclc.org, if you are interested in receiving notifications of this training.

⁵ The most recent version of CMS' guidance on the BAE policy is available online at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2240438420/area_folder.2006-10-12.1399747428.

⁶ CMS Guidance to Plans, "LIS Incorrect Cost-Sharing – Making the Beneficiary Whole," July 7, 2006, at http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/QALISMakingBeneWhole_07.06.06.pdf.

MARCH 31 DEADLINE FOR QMB ELIGIBILITY IN STATES WITHOUT BUY-IN

A reminder: in 15 states, the first quarter of 2008 is the only time when certain low-income individuals, including some senior immigrants, may qualify for valuable benefits through a Medicare Savings Program (MSP). Therefore, advocates in those states should take advantage of Medicare's general enrollment period, which ends March 31, to evaluate clients' eligibility for MSP benefits, in particular the Qualified Medicare Beneficiary (QMB) program. The 15 states are: Alabama, Arizona, California, Colorado, Illinois, Kansas, Kentucky, Missouri, Nebraska, New Jersey, New Mexico, Oregon, South Carolina, Utah and Virginia.

Enrollment in Medicare Part A (often referred to as "hospital" coverage) is a necessary prerequisite to receiving MSP benefits. The majority of states have "buy-in" agreements with the federal government that allow dual eligibles (i.e. those eligible for both Medicare and Medicaid) to enroll in Medicare Part A all year. In the remaining 15 states, however, the three general Medicare enrollment months are the only time when individuals who don't already have Medicare Part A can sign up.

MSPs provide beneficiaries with assistance in paying Medicare premiums, deductibles and co-insurance. The scope of the benefit varies depending on individuals' eligibility for particular programs. It is most meaningful for individuals, such as qualified senior immigrants, who do not have free Medicare Part A because they lack 40 quarters of work history, but whose income is low enough to receive a state subsidy for Part A through QMB. As dual eligibles, MSP beneficiaries also automatically qualify for the Low Income Subsidy ("extra help") for Medicare Part D prescription drug coverage. For more detailed information, see NSCLC's online article.⁷

ECONOMIC STIMULUS PAYMENTS WILL NOT AFFECT LIS ELIGIBILITY

On February 22, 2008, the Social Security Administration instructed that the 2008 economic stimulus payments, provided to recipients of Title II Social Security benefits, among others, will not be counted as income for purposes of determining eligibility for the Part D Low Income Subsidy. *See SSA Policy Instruction EM-08028.* If recipients do not immediately spend the rebate, it will not be counted as a resource for purposes of LIS determination until two months following the month of receipt. For instance, if an individual receives a stimulus payment in May 2008, it can be excluded from resources reported in an LIS application in June or July. The funds, if retained, need to be included as a countable resource starting in August 2008.

In order to receive a rebate, beneficiaries must file a 2007 tax return, even if they have no tax liability.

⁷ At http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.4596471630/area_folder.2006-10-31.1884975563.

CALIFORNIA SPECIFIC INFORMATION

KAISER SPECIAL NEEDS PLAN DISENROLLMENTS, INCREASED CO-PAYS FOR SOME

- **Kaiser to Disenroll Some Members from Special Needs Plan**

Kaiser Permanente announced that it will involuntarily disenroll from its Special Needs Plan (SNP) for dual eligibles approximately 6,000 members whose Medi-Cal eligibility has not been verified by California's Department of Health Care Services (DHCS). This round of disenrollments will only affect individuals who, according to DHCS, are not eligible for Medi-Cal benefits. Individuals who have Medi-Cal with a share of cost (SOC) are not included in this current round of disenrollments. Those affected will include a small number of partial duals (e.g. QMB-only, SLMB-only, QI-only). Kaiser will send a series of four letters beginning the first week of March 2008, informing recipients that they are no longer eligible for membership in the SNP and directing questions to Kaiser's call center. Members who contact the call center will be encouraged to enroll in Kaiser's standard Medicare Advantage HMO product, Senior Advantage. As SNP enrollees who have lost their special needs status, these Kaiser members have a Special Enrollment Period (SEP) that allows them, upon disenrollment, either to join another Medicare Advantage plan or to enroll in traditional Medicare with a stand-alone Part D plan.

Members who take no action will continue to receive full SNP benefits (including premiums and cost-sharing subsidies, although some will pay increased drug co-pays as described below) until July 1, 2008, when they will be involuntarily disenrolled. Kaiser members who wait until July 1 and are disenrolled will continue to get an SEP of three months following the date of involuntary disenrollment in which to either choose to join Kaiser Senior Advantage, another Medicare Advantage plan, or stay in original Medicare and enroll in a Part D plan. *See* PDP Enrollment Guidance § 20.3.8(8)(F); MA Guidance § 30.4.4(10).

- **Kaiser Increases Part D Co-Pays for Some SNP Enrollees**

For 2008, Kaiser's SNP has also instituted new prescription drug cost-sharing requirements for any members who do not receive the Low Income Subsidy (for instance, because they have Medi-Cal with a SOC and have not met their SOC since July 2007, or for any other reason failed to qualify for LIS yet remain enrolled in the Kaiser SNP). As a result, some members of Kaiser's SNP will have to pay much higher prescription drug cost-sharing in 2008 than they did in 2007. For Kaiser SNP members who do not have LIS, the 2008 prescription cost-sharing will be \$10 generic/\$42 brand/25% specialty in Southern California and \$11 generic/\$41 brand/25% specialty in Northern California.

CHANGE IN PART D PLANS CAUSES INCORRECT MEDI-CAL CODING

Some California health advocates have noticed that for some dual eligible beneficiaries, a 2008 change in Part D plan enrollment triggered an erroneous code change in their Primary Medi-Cal coding: what should have been coded “D” for a Part D plan is now coded “A” for “Other Health Coverage.” The erroneous coding has, in turn, caused concern among providers about payments.

California’s Department of Health Care Services is aware of the problem and has stated that it plans a systemic fix for this coding error. In the meantime, affected beneficiaries must call the MEDS hotline, 1-800-952-5294, for an individual file fix.

MATERIALS FOR CALIFORNIA ADVOCATES

- **Guide to Transition Drug Supply Policies**

CMS requires of Part D plans that any Part D beneficiary who switches to a new plan has a right to a “transition supply” of a 30 day refill (unless a lesser amount is prescribed) of any ongoing medication within the first 90 days of coverage under a new Part D plan, or after a plan changes its formulary to exclude or restrict access to a drug. Special transition policies also apply to beneficiaries in institutions and those experiencing a change in status, e.g., leaving a nursing home or hospital. Some plans have transition policies that are more generous than the required minimums. NSCLC has summarized CMS’ transition requirements and plans’ transition policies in a tool for advocates and consumers, “Transition Drug Supplies: CMS Requirements and Policies of Selected California Plans.”⁸

- **Consumer Guides for Assisted Living and Nursing Home Residents**

NSCLC recently produced two guides for California consumers: “10 Tips for Assisted Living Residents: A Guide for California Consumers” and “10 Tips for Nursing Facility Residents: A Guide for California Consumers,” offering practical suggestions on a broad range of important assisted living and nursing home issues, including finding the best facility, planning care, arranging for SSI or Medicaid payment, preventing evictions, and generally advocating for the high quality of care that residents deserve. The guides are useful resource not only for residents and families, but also for facility staff members, doctors, care managers, and anyone else with a personal or professional interest in assisted living or nursing homes. Each guide costs \$5.95, and one copy is provided free to each California legal services organization. Contact cross@nsclc.org or (202) 289 6976 x211 to order.

⁸ Available on NSCLC’s website at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.6262442724.

PART D NEWS & VIEWS

AGENCY ACTION

- **Proposed Benchmark Plan Regulation Fails to Provide Beneficiary Stability**

In early January, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule to address the problems caused by annual changes in the Medicare Part D plans available to dual eligibles and other Low Income Subsidy (LIS) recipients. NSCLC and other advocacy organizations filed comments taking the position that, while it is encouraging to see that CMS is concerned about the impact of these changes on low income beneficiaries, the proposed rule continues to leave beneficiaries without the stability and predictability they need.

Dual eligibles and other LIS recipients can join a Part D plan and pay no monthly premium as long as the plan's premium is below an amount known as the regional benchmark. Both plan premiums and the benchmark amount are determined by a formula which averages plan bid amounts. Since plan bids vary from one year to the next, plan premiums and the benchmark amount also vary annually.

As a result, a plan's premium may be below the benchmark amount one year, but not the next. Beneficiaries enrolled in plans that were below the benchmark one year, but not the next are put in a difficult position. If they stay in these plans they must pay the difference between the plan's premium and the benchmark amount. If they switch plans they will not have to pay a premium, but they will experience a disruption in coverage.

To date, CMS' solution has been to automatically reassign full subsidy recipients if they were auto-enrolled by CMS into plans with premiums that will rise above the benchmark. Full subsidy recipients who self-enrolled into one of these plans – also known as “choosers” – are not reassigned and, if they do not switch plans themselves, are charged a premium. During the 2007 Annual Enrollment Period, over 2.1 million full subsidy recipients were reassigned to a new plan. An additional 440,000 “choosers” had to switch plans themselves in order to avoid paying a premium in 2008.

Under the proposed rule, CMS would maintain the current reassignment process, but would also guarantee that in every region there would be at least 5 organizations offering \$0 premium plans. The proposal would allow certain plans to reduce the premium they charge to full LIS recipients to the benchmark amount so that these enrollees would pay no premium. The amount that plans would be allowed to reduce premiums for full LIS recipients would be set at a level which would ensure that in the region at least 5 organizations would be offering a plan with a premium below the benchmark amount. Plans that achieved benchmark status via this reduction would be allowed to retain current enrollees, but would not be eligible for new auto-assignments.

The essential failure of the proposed regulation is its focus on the quantity, not consistency of benchmark plans offered in a region. While the rule guarantees that there will always be a

certain number of plans available, it does nothing to guarantee that the same plans will be available from one year to the next. As a result, it will do little, if anything, to decrease current levels of reassignment and beneficiary instability.

The new rule is still just a proposal. NSCLC's comments on the proposal are available on its website.⁹ If you are interested in learning more about the proposed regulation, please contact Kevin Prindiville (kprindiville@nsclc.org).

- **Advocates Urge Increased Scrutiny of Special Needs Plans**

In January, NSCLC and other advocates called for increased scrutiny of controversial Medicare Advantage Special Needs Plans (SNPs) in response to draft evaluation measures proposed by the National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS).

SNPs are a new type of Medicare Advantage plan that disproportionately or exclusively enroll "special needs individuals," including institutionalized individuals, dual eligibles, and individuals with severe or disabling chronic conditions. SNPs began marketing to special needs populations in 2006. Although Congress has put a temporary moratorium on the creation of new SNPs through December 31, 2009, many existing SNPs continue to enroll new members.

So far, however, CMS' failure to issue substantial regulations or requirements has meant that there may be nothing "special" about Special Needs Plans. In the NCQA's draft proposal for evaluating SNPs, advocates were disappointed in a continuing lack of substantive protections for special needs individuals. The NCQA proposal lacked specific measures that would allow for the evaluation of the appropriateness of SNPs for dual eligibles. Approximately 74% of SNP enrollment is in plans targeted at dual eligibles, yet the current draft evaluation measures fail to formulate any standards specific to dual eligible SNPs or the treatment of dual eligibles enrolled in SNPs. Advocates also called for a case management process that would include an assessment of and assistance in obtaining health coverage beyond the private plan's benefits package, including all available Medicaid services.

These recommendations echo the findings of the Center for Medicare Advocacy (CMA) after an October 18, 2007 working conference that brought together beneficiary advocates, health policy advocates, researchers, SNP providers, officials from CMS, and Congressional staff to discuss and evaluate SNPs from a beneficiary perspective. CMA recommends that CMS should enact and actively enforce protections that guarantee SNP-specific beneficiary protections, standard for care, and coverage.¹⁰

⁹ Go to http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2022247391/nsclc-comments-on-proposed-medicare-part-d-benchmark-plan-regulation/at_download/attachment.

¹⁰ CMA's complete recommendations are online at <http://www.medicareadvocacy.org/SNP%20Conference/Home.htm>.

NSCLC's complete comments to NCQA and CMS are online.¹¹ For more information about SNPs, contact Anna Rich, arich@nsclc.org.

- **CMS Issues Reminder On Language Access; Advocates Demand Follow-Up**

On January 2, 2008, the Centers for Medicare & Medicaid Services (CMS) issued guidance to private Medicare plans reminding them of their responsibilities to serve limited English proficient (LEP) beneficiaries.¹² CMS' memo relied in part on the 2007 findings by NSCLC, the National Health Law Program and the California Medicare Part D Language Access Coalition that Part D call centers in California were not meeting existing obligations to provide interpreters or written translated materials. CMS also cited NSCLC and the other advocates' October 2007 report recommending best practices for Part D plans on language access issues.¹³

Although the CMS memo was a step in the right direction, much advocacy work remains to be done. In particular, CMS' current guidance fails adequately to address the needs of LEP beneficiaries for accessible written materials. CMS also has yet to explain how it will monitor Part D plan call centers, or how it will incorporate best practices on language access for 1-800-MEDICARE services. NSCLC, on behalf of members of the California Medicare Part D Language Access Coalition, has raised these concerns with CMS.¹⁴ For more information, contact Katharine Hsiao, khsiao@nsclc.org, or Kevin Prindiville, kprindiville@nsclc.org.

- **CMS "Best Practices" for Training Sales Agents and Brokers Fall Short**

CMS recently issued a memorandum to all Medicare Advantage plans concerning best practices for training their sales forces. The memo states that standards for training must be identical for all persons selling plan products, whether company employees or delegated/contracted agents. All salespersons must pass a written test. CMS strongly recommends 80% as the minimum passing score but, aside from setting out general topics to be covered, does not define the specific content or difficulty level needed for the test. Plans are expected to provide annual refresher courses. CMS also states its intention to "devote considerable oversight attention" to marketing and sales practices in 2008 and beyond.

CMS attached to the memo a one-page list of 14 training topics for PFFS plans. In addition to training on required and prohibited practices and other basics, the list includes, without elaboration, an item identified as "special considerations for dual eligible beneficiaries," but made no other reference to beneficiaries who receive the Low Income Subsidy. Special issues for limited English proficient beneficiaries also are not mentioned. No topic lists were provided for other types of plans. In light of the high incidence of marketing abuses reported to CMS, the

¹¹ Online at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2022247391.

¹² Memo is online at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2240438420.

¹³ These reports are available online at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-18.4955802464.

¹⁴ Online at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2022247391.

agency's memo was disappointingly limited and non-specific. For a copy of the memo, email Georgia Burke, gburke@nsclc.org.

ADDITIONAL RESOURCES FOR ADVOCATES

CMS MATERIALS

In addition to the materials described above, CMS has released other recent materials that may be of interest to advocates:

1. 2008 Medicare Part D Low-Income Subsidy Income and Resources Standards

In order to update the Part D LIS income and resource limits, CMS published tables providing the 2008 Federal Poverty Income Levels for the continental United States, Hawaii and Alaska, as well as a detailed description of the methodology used to update resource limits.¹⁵ The new income and resource standards apply to all LIS applications filed on or after January 1, 2008.

2. Proposed Regulations on Part D Appeals Process

CMS has issued proposed new procedures for appeals brought by Medicare Part D enrollees at the Administrative Law Judge and Medicare Appeals Council levels.¹⁶ Comments are due on May 16, 2008. For more details or to learn of advocates' plans for comments, contact Georgia Burke, gburke@nsclc.org.

GAO REPORTS

1. GAO Reviews Part D Appeals Process

The Government Accountability Office recently issued a report, *Medicare Part D: Plan Sponsors' Processing and Medicare Monitoring of Drug Coverage Requests Could be Improved*. Based on randomly selected samples of October 2006 appeals filed with plan sponsors and with the IRE (Maximus), GAO found that pressure to make a coverage determination within the CMS-mandated time frames increased the likelihood that sponsors would deny requests when complete information was not at hand or could not be obtained quickly. Problems in obtaining an appointment of representative form also frequently led to denial of claims that might otherwise be granted. GAO also found that inadequacies in CMS data collection procedures hampered effective monitoring of plan performance.¹⁷

¹⁵ Online at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.5758698482/area_folder.2006-10-12.2240438420.

¹⁶ 73 Fed. Reg. 14342 (Mar. 17, 2008), <http://a257.g.akamaitech.net/7/257/2422/01jan20081800/edocket.access.gpo.gov/2008/pdf/E8-5189.pdf>.

¹⁷ The GAO report is available at <http://www.gao.gov/new.items/d0847.pdf>.

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 and other low income advocates nationwide to discuss Medicare Part D. If you are an advocate and would like to participate, contact Kevin Prindiville of the National Senior Citizens Law Center, kprindiville@nsclc.org, or Vicki Gottlich or Patricia Nemore of the Center for Medicare Advocacy at (202) 216-0028.

2. Part D Advocates' Alert

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

3. 2008 Dollar Amounts Chart

Many of the costs associated with the Medicare Part D prescription drug benefit and the Low Income Subsidy (LIS) change every year. NSCLC has updated a detailed chart showing all of the different changing dollar amounts, the amounts for 2008 (where available), as well as the basis for the annual increase and the statutory or regulatory authority for that increase.¹⁸

4. Other Reports and Information for Advocates

- The National Health Law Program will offer an online webinar on “The Language of Drugs: Pharmacies and Language Access,” on April 3, 2008 at 2 p.m. EST/11 a.m. PST. The webinar will offer insights from work being done in California and New York to improve language access in pharmacy settings as well as an overview of relevant laws addressing the issue. Space is limited; reserve your webinar seat by registering online at <https://www1.gotomeeting.com/register/671899790>.
- David Lipschutz of California Health Advocates testified on February 28 before the U.S. House Ways and Means Committee’s health subcommittee about how Medicare Advantage plans have disadvantaged some Medicare beneficiaries: “Medicare Advantage Costs, Benefits and Oversight: the Beneficiary Experience.”¹⁹

¹⁸ Online at http://www.nsclc.org/areas/medicare-part-d/area_folder.2006-09-28.4596471630/area_folder.2006-11-02.0965172512.

¹⁹ Online at <http://www.cahealthadvocates.org/advocacy/2008/beneficiary-experience.html>.

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- The Medicare Rights Center has a schedule of future web seminars on Medicare topics plus archived recordings of seminars on its website.²⁰ Past topics include “Navigating Medicare Part D Appeals,” “Help Paying Your Medicare Part D Costs,” “Medicare Drug Plan Finder,” and “Medicare Prescription Drug Benefit (Part D).”
 - The Health Assistance Partnership (HAP) has created a new series of step-by-step guides for advocates to use when counseling beneficiaries considering private Medicare Advantage plans, including Special Needs Plans and private-fee-for-service plans.²¹
 - NSCLC has produced a federal guide for advocates about “Money Follows the Person,” a new federal program designed to assist states in transitioning Medicaid individuals from institutionalized care into the community. The piece broadly covers the basics on eligibility, implementation issues, pre-Deficit Reduction Act federal support for transition programs, and some specific information from pending and/or approved state protocols.²²
 - The Kaiser Family Foundation has released new materials on private Medicare Advantage plans: its interactive online resource, the Medicare Health and Prescription Drug Plan Tracker, has been updated with new 2008 local, regional and national data about Medicare Advantage plans, including HMOs, regional and local PPOs, private fee-for-service plans, and Special Needs Plans (SNPs).²³ KFF also released a new report, “Do We Know If Medicare Advantage Special Needs Plans Are Special?,” on the history of SNPs, how they fit into the larger Medicare Advantage marketplace, and how to assess whether special needs plans are performing differently from other Medicare Advantage plans.²⁴
 - A Government Accountability Office report found that the extra subsidies that private Medicare Advantage (MA) plans receive when compared to spending in traditional, fee-for-service Medicare do not necessarily reduce cost-sharing for MA enrollees.²⁵ According to the GAO, Medicare beneficiaries who make greater use of services such as home health care and inpatient services could face significantly increased costs when compared with traditional Medicare enrollment.
 - The Department of Health and Human Services’ Office of the Inspector General found that for local, community pharmacies, the estimated difference between Part D payments and drug acquisition costs was \$9.13 per prescription including rebates paid by drug wholesalers and \$8.78 excluding rebates. The estimated average Medicare Part D dispensing fee paid to local, community pharmacies was \$2.27 per prescription—about \$2 less than the average Medicaid dispensing fee.²⁶

²⁰ Go to www.medicarerights.org/webinars.html.

²¹ Go to <http://www.hapnetwork.org/medicare-advantage/>.

²² Go to http://www.nsclc.org/areas/medicaid/article.2008-01-23.2399931224/at_download/attachment.

²³ Go to <http://www.kff.org/medicare/healthplantracker/index.jsp>.

²⁴ Go to <http://www.kff.org/medicare/7729.cfm>.

²⁵ Go to <http://www.gao.gov/new.items/d08359.pdf>.

²⁶ Go to <http://www.oig.hhs.gov/oas/reports/region6/60700107.pdf>.

NSCLC's D.C. Office Has Moved!

As of January 26, 2008, the National Senior Citizens Law Center's Washington, D.C. office has moved to:

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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 a **"Client Story Form"** to report problems your clients have faced. You can access the form at www.nsclc.org/areas/medicare-part-d. If you would rather not use the form, a plain email is fine too. 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.

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