Senior Health News

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Passive enrollment lawsuit against CMS settled

On March 31, 2006, PHLP, Community Legal Services, and the Center for Medicare Advocacy settled Erb v. McClellan, the lawsuit that we filed against the Centers for Medicare and Medicaid Services (CMS) on behalf of dual eligibles who had been passively enrolled into Medicare HMOs. With this settlement, people who were passively enrolled into a Medicare HMO have some additional protections and more time to figure out their benefit. The key terms of the settlement are described below. A copy of the settlement agreement can be found on our website at www.phlp.org.

Extension of the transition period.

Under the settlement, the transition period will be extended until June 30, 2006. This means that passively enrolled individuals can continue to see out-of-network providers and not have to obtain referrals or prior authorizations and can continue to obtain off-formulary drugs they were taking before January 1 without prior authorizations or other obstacles until June 30, 2006. Starting July 1, 2006, dual eligibles who are still enrolled in the Medicare HMOs will be limited to only the providers that participate with that Medicare HMO, will be limited by the plans formulary of drugs it covers, and will be required to comply with all prior authorization and referral requirements the plan normally imposes.

ALL passively enrolled individuals need to make a decision by June 30 about whether to stay in the HMO or disenroll. If in doubt about whether the HMO will cover the providers and medications the individual relies on, we recommend that the individual disenroll.

Ways to disenroll

Consumers who were passively enrolled into a Medicare HMO can always disenroll at any time by calling 1-800-MEDICARE or by enrolling into another plan, to be effective the first of the next month. Under the settlement, until June 30, 2006, there are other ways for people who have been passively enrolled to be disenrolled from the Medicare HMO. Other methods are:

- Calling 1-800-Medicare and asking to be disenrolled effective either the first of the next month (prospective disenrollment) or the first of the current month (retroactive disenrollment)

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- Faxing written disenrollment requests to the CMS Regional Office at 215-861-4334. There is no required form that these written disenrollments must take. And, providers may fax these in for their patients. A simple "I, John Doe, request to be disenrolled from Medicare HMO XYZ " that Mr. Doe signs should be enough to get Mr. Doe returned to original Medicare. (Note that if Mr. Doe wants to pick a drug plan, the note can include that. Note also that if Mr. Doe does not pick a drug plan, he will be auto-assigned to one (but can still change from month to month).

When disenrolling from a Medicare HMO, consumers should be sure to choose a new, stand-alone prescription drug plan (PDP) so that they are not left without prescription drug coverage. Consumers can get help choosing a new plan by calling 1-800-MEDICARE or by calling APPRISE at 1-800-783-7067.

Those who request disenrollment will receive confirmation of their disenrollment request within 7 days and will be held harmless for any charges resulting from delays in processing of their disenrollment. This means that if the disenrollment does not go through properly, the consumer will not owe money to the providers or the plan for any bills they may get.

Notice to consumers and providers

A new notice should have gone out to passively enrolled dual eligibles from CMS informing them of the extension of the transition period and of their options for disenrollment or deciding whether to remain in the plan. In addition, providers should also receive a notice from CMS letting the providers know about the extension of the transition period. Providers who are not part of the HMO network and are seeing passively enrolled patients during the transition period should be paid at the Medicare Fee-for-Service rate or at their billed rate, which ever is lower. These notices are available on the www.phlp.org website.

Before the end of June, each Medicare HMO into which dual eligibles were passively enrolled must contact all enrollees who have been using out-of-network providers (through the transition plan and in the last 3 months of 2005) if their out-of-network provider will not be joining the HMO's network and inform the dual eligible that the provider will not be joining the plan and thus that the individual must choose another form of coverage or another provider by June 30, 2006.

All problems should be reported to the Pennsylvania Health Law Project (800)274-3258 or ahalperin@phlp.org so that we can convey them to CMS for monitoring and enforcement. The litigation is positioned such that it can be reopened in the event that implementation is sufficiently flawed.

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Jennifer Nix, at jnix@phlp.org to change how you get the Senior Health News.

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Please distribute or post this flyer!

April 2006 Brings "Facilitated Enrollment" for Some Low-Income Pennsylvanians into a Part D Medicare Drug Plan

Who will get Facilitated Enrollment?

Two groups of Pennsylvanians will have their Part D Enrollment Facilitated in April if they have not yet chosen a Medicare Prescription Drug Plan:

1) Persons who are dual eligibles but do not get full Medical Assistance benefits (for example, those that have Medicare and for whom Medicaid pays only their Part B Premium)
2) Pennsylvanians who are enrolled in the Partial Low-Income Subsidy

What is Facilitated Enrollment?

The Centers for Medicare and Medicaid Services (CMS) will auto-assign these "Other Dual Eligibles" who have not signed up on their own for a PDP. Letters will be sent to these consumers beginning in April on GREEN paper. These letters will list a randomly assigned prescription drug plan and inform the individual that, if they do not choose to join a different PDP by April 30, 2006, they will be enrolled in the plan that is listed in the GREEN letter effective May 1, 2006.

Do I need to do anything about this?

CMS has randomly auto-assigned consumers to PDP's, so the one you have been assigned may not be the one that best suits your needs. It would be a good idea to call 1-800-MEDICARE (1-800-633-4227) to find out if that PDP covers the drugs you need, and, if it does not, to change to a plan that does cover your drugs. It is important that you do this research and decide either to remain in the plan you were assigned or to change plans by May 1, 2006 so that you do not have a gap in drug coverage.

Am I stuck with the plan assigned to me?

No. For as long as you receive the partial subsidy or remain a dual eligible, you may change plans at any time, effective the first day of the next month. Eligibility for the subsidy and for Medicaid is reviewed and renewed annually. If you become ineligible, you may not be able to switch plans again until the next enrollment period, which is not until November 2006.

For more information, call the PHLP Helpline at 1-800-274-3258.

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PHLP to launch a Medicare Part D listserve

Next month, the Pennsylvania Health Law Project will be starting an e-mail list serve to provide members with monthly updates on new developments in Medicare and Medical Assistance. The list serve will be staffed by the Pennsylvania Health Law Project with statewide information and discussion but special attention to the 5 County Philadelphia area. In addition to updates, the list serve will also be a forum for advocates to discuss issues around Medical Assistance and Medicare. In an effort to identify the key issues that you are seeing, we have included (on the next page) a survey that we ask you to complete. The responses will help guide the initial discussions of the list serve group.

The list serve will be private, meaning that only individuals who express an interest in being placed on the list serve will be allowed. When the list serve is launched, people who have expressed an interest in being on the list serve will receive an email, inviting you to join. Joining is free and you can remove yourself from the list at any time. If you have any questions or would like to join, please contact Jennifer Nix at jnix@phlp.org. The creation of the list serve is supported by a grant from The Pew Charitable Trusts.

Trainings on Medicare Part D Issues and Implementation available in SW Pennsylvania

Have you been spending the last few months trying to help consumers through the maze of Medicare Part D? PHLP's Pittsburgh office has been conducting trainings throughout the SW Region providing advocates and providers with the most updated information on enrolling into a Part D Plan and using the benefit. The trainings include a discussion of the many implementation issues that have arisen and how to address them, as well as how to file appeals and grievances.

If you are interested in scheduling a training for your staff and/or the consumers you work with, please call PHLP at (412) 434-5779, 1-800-274-3258, or 1-800-236-6310 (TTY). Let us know if you require any special accommodations for hearing and/or visual impairments and we would be glad to accommodate your needs.

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COMPLETE AND RETURN

Many Dual Eligibles are Having Problems With Part D.

Please share the problems you are seeing for your Dual Eligibles.

Your Name: _____ Your Organization: _____

Your County: _____ Your e-mail: _____

Date: _____

I am currently seeing the following problems in my work:

[ ] Dual eligibles who have not been assigned to a plan.

[ ] These individuals were not auto-enrolled OR [ ] These individuals declined auto-enrollment?

[ ] Dual eligibles who have changed plans or selected their own plan

[ ] but whose enrollment into the new plan has not taken effect

[ ] Yes [ ] No Duals are having trouble getting medications.

[ ] Yes [ ] No Requested the new enrollment last month but it is not effective this month.

[ ] Yes [ ] No Requested the new enrollment two months ago but it is not effective this month.

[ ] Yes [ ] No Requested the new enrollment three months but it is not effective this month.

[ ] but who appear to be enrolled in 2 plans.

[ ] Yes [ ] No Duals are having trouble getting medications.

[ ] Yes [ ] No Efforts have been made to clear up enrollment confusion.

[ ] Dual eligibles whose plan has informed them they will be changing their formulary/covered drugs.

[ ] Yes [ ] No Duals will lose coverage for 1 or more medication due to the formulary change.

[ ] Dual eligibles who have been denied medications and

[ ] Yes [ ] No have requested exceptions to their plans formulary

[ ] Yes [ ] No have appealed the decision not to cover a formulary drug

[ ] Dual eligibles who should automatically have the Extra Help/Low-Income Subsidy but are being charged more than the $1-$5 co-pays that dual eligibles are supposed to be charged

[ ] Yes [ ] No They are paying the higher amount themselves.

[ ] Yes [ ] No They are using the state's special coverage (insures the $1-$5 co-pay amount)

[ ] Yes [ ] No These individuals are going without medications.

[ ] Dual eligibles who are on HCBS Waivers and having trouble affording the co-payments.

[ ] Dual eligibles who live in Personal Care Homes and are having trouble affording the co-payments.

[ ] Other problems for dual eligibles: _____

We need details!! Please add any notes, explanations, or examples of the problems you have seen to a separate page. We may contact you for more information. Please separately contact us about passive enrollment access problems.

Please fax to 215-625-3879 or e-mail to ahalperin@phlp.org

Medicare Recipients in 2 Medicare Prescription Drug plans get letter from CMS

There have been many "glitches" or computer systems problems at CMS. As a result, many individuals appear in 2 Medicare Prescription Drug plans. Usually, at least one of the plans is one the individual has selected.

Beginning in April, CMS has been sending letters to individuals who appear to be enrolled in 2 plans informing them on the error and urging them to confirm which plan is the plan they, in fact, want to be in. The letter lists the 2 plans the person appears to be in. The letter then lists the plan CMS thinks the individual wants to be in and indicates that, unless the person responds, CMS will maintain their enrollment in that plan and terminate their enrollment from the other listed plan.

In some instances, we are already aware of errors in these letters. For example, the plan CMS "thinks" the person wants to be in is a plan they requested disenrollment from months prior. It is critical to check these letters carefully and act swiftly to insure that all Medicare beneficiaries end up in their plan of choice. While dual eligibles qualify for a continued special election period and can change plans at any time, most others do not and will be locked into a plan until 2007. It is important to be sure the plan they have is the one they want. Please be on the lookout for these letters and encourage consumers to respond to them.

Waiver Participants and PCH Residents struggle with Part D co-payments

A federal bill would address the inequity of the Medicare Modernization Act of 2003 in its treatment of individuals in nursing homes when compared to their counterparts who elect to remain in the community. At present, the federal law permits no prescription drug co-payments to be charged to dual eligibles who live in nursing homes or ICF/MR institutions. Those who are clinically eligible for residing in these locations but choose instead to remain at home, are charged co-pays. Many waiver recipients struggle to pay these co-payment amounts. Low-income PCH residents face a similar challenge. They receive only $60 each month for all their personal needs. For many, the $1-$5 co-pays alone are depleting their entire personal needs allowance.

Senate bill 2409 "the HCBS Copayment Equity Act of 2006" would eliminate co-payments for dual-eligible Medicare beneficiaries (those who qualify for both Medicaid and Medicare coverage) who reside in community based settings and in personal care homes.

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The PACE Program—An Update

The PACE program is the Pharmaceutical Access Contract for the Elderly. It is a program for lower-middle and middle income Pennsylvanians over 65 to obtain prescription drugs. The program is funded by the Pennsylvania Lottery. Governor Rendell has announced the PACE plus Medicare program, a proposal to allow PACE to wrap-around the Part D benefit for all PACE enrollees.

Under the law, PACE applicants cannot have other prescription drug coverage and be eligible for the PACE program. Senator Pat Vance has introduced legislation SB 1188 that would permit individuals with Part D coverage to be eligible for the PACE program.

If passed, the PACE program would help PACE members identify the Part D plan that best covers their prescriptions, would encourage them to enroll, would help with the Part D monthly premiums, and would cover any medications that cannot be obtained through the Part D plan. In essence, the PACE program would save money by shifting a significant portion of the drug coverage costs to the Part D program while guaranteeing PACE members the broadest possible access to medications, at no additional cost to the PACE members.

It is unclear whether the new PACE bill, if passed, would permit dual eligibles to join the PACE program. Overall, dual eligibles are frailer and more medically complex than their higher income counterparts. They take more medications. And, since the start of Part D, have had a hard time identifying plans that cover their entire array of prescriptions. Duals lack the disposable income to pay out of pocket for medications their Part D plans do not cover and would greatly benefit from PACE helping to cover the medications their Part D plans do not.

Individuals on behalf of dual eligibles have begun advocating with the state and the legislature to ensure that dual eligibles too would have access to PACE to fill the gaps in their coverage created by Part D. Advocacy to provide similar benefits to individuals with permanent disabilities under 65 continue as well.

Cuts seen for HCBS Waivers! Tell us your story.

Home and Community Based Services Waiver recipients are being hit by efforts to control the state's long term care budget and create a uniform system statewide. Clients from around the state are beginning to report cuts to services or even terminations from the program. This on top of mounting waiting lists for state and Medicaid funded HCBS programs is alarming consumers and their advocates.

HCBS Waivers are critical to keeping adults with disabilities and seniors at home and as active participants in their community and for permitting them to age in place. Remember that level of care and service package determinations are appealable! Call 1-800-274-3258 or e-mail us at staff@phlp.org to share your story or request guidance/assistance in appealing.

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WHAT IS THE PENNSYLVANIA HEALTH LAW PROJECT?

PHLP is a non-profit public interest law firm that provides free legal services to low income, elderly, and individuals with disabilities throughout Pennsylvania on certain healthcare problems related to Medicare, Medicaid, CHIP, etc. We have offices in Philadelphia, Harrisburg, and Pittsburgh.

People call us when they are having trouble getting: prescriptions filled, transportation to their doctors, referrals to specialists, their healthcare plan to approve or continue a service, etc. Or for assistance in establishing or appealing their eligibility for publicly funded healthcare programs. For information or help, please call us at 800-274-3258/ TTY 866-236-6310 or e-mail us at staff@phlp.org. Or, check us out on the web at www.phlp.org !!

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