MA/PDP Enrollment Guidance - Draft Update

Comment Form

Comments due 5:00 p.m. EDT July 2, 2010

Please e-mail all comments to PDPENROLLMENT@cms.hhs.gov

Organization Name: California Health Advocates; Center for Medicare Advocacy; Community Legal Services, Philadelphia; Medicare Advocacy Project, Greater Boston Legal Services; Medicare Rights Center; National Senior Citizens Law Center

Document (Specify MA or PDP)	**Section number and Page number**	**Description of Issue or Question**	**Suggested Revision/Comment**
MA	Entire Document; §10	The guidance repeatedly refers to "Authorized Representative." This term was abandoned for "Representative" by CMS in the final rule released on April 15, 2010. There is no definition of representative or the term "legal representative," which is used throughout the document.	Please delete the word "authorized" and "legal" in the guidance and the notices. The term "representative" should be included in the definition section and the definition should include those individuals appointed by virtue of Form CMS 1969 (Appointment of Representative).
MA and PDP	Entire Document	The term to describe the new "disenrollment Period" in January and February is inconsistent throughout and between the Medicare Managed Care Manual and the Medicare Prescription Drug Manual. In the Managed Care Manual it is called the "Managed Care Disenrollment Period" and in the Prescription Drug Benefit Manual it is called the "Annual Disenrollment Period."	To avoid confusion, the title of the new "disenrollment period" should be consistent throughout all CMS documents and guidance. Previous documents issued by CMS have used the term "Annual Disenrollment Period" (ADP) as used in the draft Part D enrollment guidance. We recommend that CMS adopt this language as it is already used in the community and previous releases and will avoid further confusion.
MA	§10, p.8; §30.4, p.32; §60.2 and §60.2.1, p.124	Cancellation of Enrollment Request: We request more clarity in §10 and §30.4 so that they may not be read to contradict §60.2 and §60.2.1, p.124, which allow for cancellations of enrollment.	Revise §10, p.8 Cancellation of Enrollment Request to read: "A cancelled enrollment request <u>means that the election</u> has not been used…" Revise §30.4, p. 32 to account for cancelled enrollment by eliminating the last two sentences in the last paragraph on p. 32 and replacing them with: If there is a cancellation of enrollment, that means that the election has not been used, and the SEP ends with the end of the SEP time frame or the effective date of a new

			enrollment, whichever comes first. Once the individual's new MA plan becomes effective, the SEP ends for that individual even if the time frame for the SEP is still in effect. In other words, **the individual may not make anymore changes, including cancellations, once the new MA plan becomes effective or when the SEP time frame ends, whichever comes first, unless specified otherwise for an SEP.**
MA	§20.4.2, p. 21	The passive enrollment process does not allow for input from affected enrollees.	Enrollees should be granted a SEP that allows them to switch plans if they are passively enrolled in another plan.
MA	§30.4, p. 34	In the section titled "Other Low Income Subsidy" in which there is suggested questions to determine if an SEP is available, there should be an additional question about the costs the individual pays for prescriptions. Many individuals are not aware that they do receive extra help, or what it is. However, by determining the individual's co-pay amount, the plan will be able to determine if the individual is receiving extra help.	We suggest you add another question: How much do you pay for your prescriptions?
MA ***	§30.4.1, p.35, 36	"SEPs for Change in Residence" – Revise involuntary disenrollment of individual who has been out of the service area to reflect that disenrollment may occur on the first day of the 13th month if the plan offers a visitor/travelers program for an individual who is out of the area longer than 6 months but less than 12 months.	Revise the last sentence in the paragraph, Disenrollment from Previous MA Plan, to reflect that disenrollment may occur on the first day of the 13th month if the plan offers a visitor/traveler benefit and the conditions described in 42 C.F.R. 423.74(d)(4) are met.
MA	§30.4.2 p. 36	Although this section includes language about an SEP for individuals where an MA organization or agent materially misrepresented the MA plan when marketing it, there should be a provision for an SEP when the member was enrolled in an MA plan as a result of a marketing violation. For instance, if the individual was enrolled after an unsolicited visit to the home, or approached at a physician's office.	Suggested Revision: Additional clause providing for an SEP for individuals enrolled in an MA plan as a result of a marketing violation: …or the individual was enrolled in the MA plan as a result of an action by the MA organization or its agent that violated Medicare marketing regulations…
MA	§ 30.5, Page	We encourage clarity in implementation of the creation	This section states that individuals in MA-only plans

	44	of an SEP to allow individuals to enroll in a PDP during the new "annual disenrollment period" regardless of whether the MA plan from which they are disenrolling included Part D drug coverage.	who use the MA DP to disenroll from their MA plan are also eligible for a SEP to enroll in a PDP. To highlight the difference in the beneficiary options in this new SEP compared to the former OEP, the language in both the MA Enrollment Guidance and the PDP Enrollment Guidance needs to be clear that people leaving MA-only plans have a SEP for the PDP. We suggest that the first sentence in the second paragraph of § 30.5 on p. 44 be incorporated into the PDP guidance that establishes the SEP for the MA DP, §30.3.8.D, pp. 30-31 of the Enrollment Guidance.
MA	§30.6, page 45	There is nothing provided about how an organization should attempt to contact someone to determine his or her preferred effective date nor how these attempts should be documented.	Suggested revision: Accessible documentation of any and all such attempts that includes, at a minimum, the date, time and result of the attempt, shall be kept by the organization.
MA	Section 30.6, Page 45	The chart on effective dates on page 45 needs to be clarified. Under the column for "Do MA organizations have to accept enrolment requests in this election period," the guidance says "Yes" for "Medicare Advantage Disenrollment Period" row (see comment pertaining to consistency for titles of enrollment periods). Under the new "disenrollment period" people may disenroll in MA plans but may not enroll in them.	The chart should make this clear and use the language included on the chart on page 47, "MA plans cannot accept enrollment requests during this period unless the enrollee has another valid election period available. Individuals disenrolling from MA may use the coordinating SEP to request enrollment in a PDP. Moreover, we request clarification as to how members of PFFS plans without Part D coverage may use the annual disenrollment period (MA DP) to disenroll from the PFFS and simultaneously join a PDP. As currently described, consumers may be confused and fail to properly make use of the MA DP and the associated SEP to join a PDP.
MA	§30.9, Page 48	As a result of the elimination of the OEP, the language from this section has been changed to state that an MA plan may choose to close one or more of its plans to OEPI enrollment requests. The OEP and OEPI are not interchangeable. The OEPI is a continuous enrollment period for institutionalized individuals that allows these consumers to change plans at any time during the year.	CMS should not allow plans to close to OEPI enrollment. This policy will limit the number of plans available to institutionalized individuals and may result in cherry picking.

		Allowing an MA plan to close to OEPI enrollment creates the potential for risk aversion and cherry picking. Institutionalized individuals tend to have more serious health issues and are therefore more expensive to cover and less desirable for plans.	
MA	§40, Page 50	We support guidance that requires MA plans to make outbound education and verification calls. This will help assure that consumer properly understand plan benefits and rules. This also provides an opportunity to further screen for marketing violations, abusive agent practices, and improper enrollment based on misinformation.	CMS should require that sponsors during OEV document all incidents of enrollments based on misconduct by agents, brokers, or plan representatives, such as misrepresentation of plan benefits, marketing abuses, or improper contacts, and report such incidents to CMS. In addition, please require plans to encourage individuals to call their local SHIP. In addition, if possible, as part of the fundamental information plan sponsors must share on OEV calls, sponsors should state star ratings. This section should expressly reference and provide the link to the Medicare Marketing Guidelines.
MA	§40, page 51	OEV calls should be closed by encouraging applicants to call their SHIP. Ideally this recommendation should be in lieu of calling 1-800-MEDICARE but, if not, at least in addition to calling 1-800-MEDICARE.	Comment: 1-800-MEDICARE has historically not been helpful or reliable in exploring enrollment options
MA	§30.4.3, p.37 and §40, p.51	§40 – Special rule for AEP (p.51) needs to be reconciled with §30.4.3 (pg.37) SEPs for non-renewals or terminations	According to § 30.4.3, enrollees in terminating/non-renewing plans have a SEP that runs from October 1 – January 31, with enrollment becoming effective on January 1 for those who make enrollments from October 1 – December 31. §40, Special Rule for the AEP, says that MA organizations may not solicit submission of paper enrollment forms or accept telephone or on-line enrollment requests prior to the beginning of the AEP. §40, Special Rule for the AEP should refer to §30.4.3 and make provisions for beneficiaries who are exercising their SEP before the beginning of the AEP.
MA	§40, p. 51	The section describing the requirement for outbound educational calls should require that the MA organization determine how the individual was contacted	Suggested Revision: Addition to language on second paragraph on p. 51:

		and enrolled by the broker or agent. This will ensure that individuals were not enrolled as a result of a marketing violation. This should be documented by the MA organization. In instances where individuals were enrolled as a result of a marketing violation (door to door solicitation, unsolicited phone calls, etc.), the MA organization should be required to report this to CMS. Calls to LEP beneficiaries also need to be conducted in the beneficiary's preferred language, which is particularly important since many of the worse marketing abuses have occurred with LEP beneficiaries.	"The purpose of performing outbound enrollment verification calls is to ensure applicants have an understanding of the product type and plan into which they are enrolling, and that the applicant is not enrolling as a result of a marketing violation or a material misrepresentation of the MA plan by an agent or broker. The MA organization must document how the applicant came into contact with the agent or broker, and how s/he applied to enroll in the plan. If the MA organization determines that the applicant has applied for enrollment potentially as a result of a marketing violation, it must document this and report it to CMS." If a beneficiary has indicated a language preference on the application, the OEV call should be made in the beneficiary's preferred language. Plan representative scripts also should emphasize that reps should make the offer of interpreter services if an individual appears to have limited proficiency in English.
MA	§40, p. 52	It is unclear how it will be confirmed that enrollment requests received prior to the start of the AEP were not solicited.	Suggested revision: For enrollment requests received prior to the start of the AEP, OEV calls should be required to confirm that these requests were not solicited.
MA	§40.1.1, p. 53	Not requiring sponsors to include the plan premium on their enrollment mechanisms is a missed opportunity to provide important information. Including this information would not be detrimental to plans or potential enrollees.	All sponsors should be required to provide the plan premium on their enrollment mechanisms.
MA	§40.1.5(C), p. 60	Although there is nothing to prohibit a dual-eligible from enrolling in an MA-only plan, many duals do enroll in an MA-only plan, because they are confused and/or do not understand that they will not have prescription coverage. In almost all cases, when a dual-eligible individual enrolls in an MA-only plan it is against her interest. MA organizations should be required to verbally explain to all dual-eligible individuals that they will have no prescription coverage, and document either in writing or by oral recording that these individuals understand they will have no prescription coverage.	Suggested Revision: "To ensure they understand the consequences of doing so, MA organizations must contact the individual by telephone and explain they will have no prescription coverage. The MA organizations then must record the individuals understanding in either a writing signed by the individual or by recording the individual's oral confirmation that she understands she will not have prescription coverage".

MA	§40.1.5(E), p. 62	Again, although full dual-eligibles may opt-out of Part D coverage, it is rarely in their best interest. Because dual-eligibles will rarely have any cost associated with Part D coverage other than minimal co-pays, it is in their interest to maintain Part D coverage. MA organizations should be required to explain that there will be little cost to the individual to maintain Part D coverage. Plans should also seek to determine why the individual wants to opt-out, and work with the individual to address these concerns.	Suggested Revision: "The MA organization should counsel the individual to ensure they understand the implications of their request to decline, and confirm this in writing…The MA organization should explain that because the individual is a dual-eligible, there will be little, if any, costs to the individual. The MA organization should seek to determine why the individual wants to opt-out of Part D coverage, and counsel the individual regarding these concerns".
MA ***	§40.1.8,Page 69-70,	This section is unclear.	This section should be revised to clarify that it is relevant to MA-PDs only and not all MA plans. In addition this section should note that LIS beneficiaries are able to switch Part D plans at any time during the year. Several of the subsections refer to "gaining" PDPs. Does CMS intend to reassign LIS –eligible individuals to MA-PDs that are LIS-eligible? If so, that should be made clearer, and the circumstances of when such reassignment might occur (ex., termination of LIS-eligible MA-PD offered by same sponsor) should be included in the section.
MA	§40.2.1, p. 78	The first full sentence on page 78 includes a "the" in front of CMS. This should be removed.	Remove "The" in front of CMS in the first full sentence.
MA	§40.2.3, p. 79	The first paragraph of this section is misleading. It states that an MA organization must deny an enrollment within 10 days of receiving an enrollment request based on …(2) an individual not providing information to complete the enrollment request within the times frame described in 40.2.2. The timeframes in 40.2.2 require that an MA organization give an applicant 21 days to submit additional information after the request for additional information. An MA organization cannot deny an enrollment within 10 calendar days of receiving an enrollment request for failure to provide information, and at the same time comply with 40.2.2 This language should be revised for clarity.	Suggested Revision: An MA organization must deny an enrollment within 10 calendar days of receiving an enrollment request based on its own determination of the ineligibility of the individual to elect the MA plan. An MA organization must deny an enrollment request if an individual fails to provide information to complete the enrollment request within the time frames described in 40.2.2

MA	§50.1.4, p. 95	The third scenario states an MA organization can deny a request when an individual does not provide required information within the required time frame. What is the required time frame?	Suggested Revision: Add the required time frames or cite the section where the time frames are listed.
MA	§50.2.1.5, p. 102	Discrepancy between PDPs and MA-PDs. The time limit for being out of a plan's service area is 12 months for PDPs.	Change time limit to 12 months to make it equivalent to time limit for PDPs.
MA	§50.2.5.; p. 104-107	Loss of special needs status - notice requirements	Organizations should be required, rather than just encouraged, to follow up with members and to issue interim notices prior to the expiration of the period of deemed continued eligibility. We appreciate the change that requires the SNP to provide a member the full length of the period of deemed continued eligibility if timely notification of the potential for involuntary disenrollment was not provided. We agree that the SNP must include an explanation of the delay.
MA	§50.3.1, p. 111	The last full sentence in the last paragraph before "Option 2" contains a however that should be removed.	Suggested revision: Remove the semi-colon and however in the last sentence.
MA ***	§50.3.1, pp.113	Failure to pay premiums: optional exception for dual eligible and LIS-eligible individuals. The guidance allows an MA organization the option to retain dual eligible and LIS-eligible individuals who fail to pay a premium even if they have a policy to disenroll members for non-payment. This policy is designed to protect individuals with limited ability to pay premiums. However, the policy is not applied uniformly. Some individuals remain in plans because they are not billed and do not know that they owe a premium. We have assisted individuals who have received bills for premiums more than a year later than they were owed, and who have even been contacted by collection agencies.	We request that CMS amend this section (1) to require plans that do not exercise the Optional Exception to send monthly bills for premiums to dual eligibles and LIS-eligible individuals; (2) to preclude plans from billing dual eligibles and LIS-eligible individuals for more than two months in back premiums; (3) to preclude plans that choose not to adopt the Optional Exception in a subsequent year from billing their eligible members for years in which the Optional Exception was in place; and (4) to preclude plans from sending to collection agencies or engaging in collection tactics with regard to premium bills for individuals who are eligible for the Optional Exception.
MA	§50.3.2, p. 116	This section should include language that states MA organizations cannot disenroll members for exercising	Suggested Revision:

		appeal/grievance rights within the plan system itself, or with CMS.	The MA organization may not disenroll a member because he/she exercises appeal or grievance rights, either within the MA organization grievance system itself, or with CMS.
MA	§50.3.2, p 115	The advance notice should be required to include specific behaviors that the MA organization considers to be disruptive. Additionally, the MA organization should be required to explain to the individual how the allegedly disruptive behavior "substantially impairs the MA organization's ability to arrange for or provide services to either that particular member or other members of the plan".	Suggested Revision: The notice must inform the individual specifically of the behavior it finds disruptive, and explain to the individual how the behavior substantially impairs the MA organization's ability to arrange for or provide services to either that particular member or other members of the MA organization.
MA	Appendices	Translation of model materials	We were pleased to see that, in its May 19, 2010 memo to plans, CMS issued specific guidance about the data that must be used to determine whether a plan is required to translate documents into languages other than English. To further facilitate improved service to LEP beneficiaries and since most plan translation responsibilities will be for Spanish translations, we urge CMS to consider creating Spanish translations of the model documents and requiring plans that are serving areas that meet the threshold for Spanish to use the model translations. Creating a single set of translated documents would serve several purposes. It would bring administrative simplification and avoid duplication of effort both by CMS and by plans. CMS would not be reviewing different translations by dozens of plans. A single model translation also would foster use of uniform Spanish vocabulary around Part D, making it easier for Spanish speakers to understand the program. Finally and perhaps most importantly, having model documents would encourage plans that are not required to translate documents to do so voluntarily because model translations are easily available. We hope CMS could eventually develop translated models in other languages as well, but Spanish would be a good first step. We also reiterate comments we have made repeatedly

			that the 10 percent threshold for translations, which is set out in CMS's language access plan, is grossly inadequate to meet the needs of LEP beneficiaries and is entirely disproportional to the HHS and DOJ plans, which set safe harbors at 5 % or 1,000 people, whichever is smaller. Under CMS LEP guidance, a plan can serve tens of thousands of beneficiaries speaking a non-English language and not have any obligation to provide translated materials.
MA	Exhibit 1A, p. 152	PACE program should be defined. In PA, PACE is also a name for the state pharmacy assistance program. This could be confusing to individuals.	Suggested Revision: I recently left a Program of All-Inclusive Care for the Elderly (PACE).
MA	Exhibit 6d P195	Refer beneficiary to SHIP for Medigap information, such as guaranteed issue rights, rather than 1-800-Medicare. In several states, like Massachusetts, there are state specific Medigap requirements. 1-800-Medicare is not familiar with these requirements.	Change language to: "Please contact <SHIP name and number> or 1-800-MEDICARE (1-800-633-4227) for further information about Medigap policies."
MA ***	Exhibit 29, p. 240	Other than individuals with retiree health coverage, there is rarely any situation where a dual-eligible individual needs to be in an MA-only plan. This notice should include more information for individuals declining Part D coverage and remaining in a MA-only plan. This information should include the fact that the member will have no prescription drug coverage, that the cost to be in an MA-PD plan will not be more than being an MA-only plan, and that the individual will have very minimal co-pays for prescription drug coverage.	Suggested Revision: Because you have declined Medicare prescription drug coverage, you will likely not have any prescription drug coverage. Medicaid will not pay for your prescriptions. Remember, switching to a Medicare Advantage plan with prescription drug coverage will not result in any additional cost to you. Additionally, you will have minimal co-payments for medications; at the most you will pay $3.20 for a non-generic medication. We strongly encourage you to join a Medicare prescription drug plan.