MDS Alert

Medicare: Big Mistake: Are You Disenrolling Beneficiaries From MMPs & MA Plans?

Take 2 crucial steps to keep state surveyors at bay.

If your facility is disenrolling beneficiaries from Medicare Advantage (MA) plans and Medicare-Medicaid plans (MMPs), you're going to get into hot water with the **Centers for Medicare & Medicaid Services** (CMS).

Why? "CMS continues to see an unacceptable practice of nursing homes disenrolling beneficiaries from these plans without the beneficiary's or the representative's knowledge or complete understanding," according to the **Texas Department of Aging and Disability Services** (DADS) in a May 29 provider alert.

"Only a Medicare beneficiary, the beneficiary's legal representative, or the party authorized to act on behalf of the beneficiary under state law can request enrollment or voluntary disenrollment from a Medicare plan," DADS warned.

Bright Spot: You're Not Alone

Apparently, the problem of facilities disenrolling beneficiaries without their knowledge is such a big problem that CMS issued a special memo to long-term care (LTC) facilities on May 26. In the memo, CMS warned that it's seeing an unacceptable practice of LTC facilities disenrolling beneficiaries from MA prescription drug plans (MAPDs) and enrolling them into stand-alone drug plans (PDPs) "without the beneficiary's or the representative's knowledge and/or complete understanding."

In fact, CMS claims that it and states have received "mass requests, all initiated and completed by LTC facility staff, to opt out or disenroll LTC facility residents from MMP coverage under the Financial Alignment Initiative."

"This action automatically returns the beneficiary to Original Medicare coverage for those services covered by Parts A and B," the memo stated. "This practice is noncompliant with regulatory requirements."

CMS goes on to say that it's seen similarly unacceptable practices among LTC facilities serving MMP beneficiaries eligible as part of the demonstration under the Financial Alignment Initiative. CMS has received complaints from beneficiaries and their representatives that after discharge from the LTC facility, they discovered they were disenrolled from their MAPD plan without their consent.

Typically, the beneficiary doesn't find out about the disenrollment until he tries to access services or starts receiving bills for services that he thought the MAPD plan should cover, the memo explained.

Take 2 Steps to Stay Compliant

What to do: Ensure that any change to a beneficiary's healthcare coverage is initiated by the beneficiary or his representative not a facility staff member. If a beneficiary or his legal representative requests assistance from your facility in changing his healthcare coverage, CMS requires you to:

1. Explain orally and in writing the impact to the beneficiary if he changes to a stand-alone PDP and Original Medicare. The information you provide should at a minimum include:

a. A clear explanation that the beneficiary would no longer be a member of the MAPD or MMP;

b. An explanation that providers will bill medical services to Original Medicare and/or Medicaid and what this means regarding deductibles and copays, as well as loss or lack of supplemental coverage;

c. The name of the drug plan that will cover the beneficiary's medications, including the deductible and copays/coinsurances related to his current drug therapy;

d. Specific information regarding the beneficiary's opportunities to change Medicare plans and Medicare prescription drug coverage while in the facility and when discharged or by virtue of being eligible for Medicare and Medicaid;

e. An explanation that enrollment in the PDP will be effective the first day of the month following the month of enrollment/disenrollment; and

f. An explanation that in some cases the beneficiary may not be able to reenroll into the MA or MAPD plan that he previously had (or into any MA or MAPD plan), even if he has a valid election period.

2. Develop written policies and procedures regarding the process of assisting beneficiaries with changing their healthcare coverage that at a minimum include:

a. Under what circumstances the facility can assist a beneficiary with a plan change;

b. The need to obtain a document signed by the beneficiary or representative that acknowledges the specific information regarding the impact of a change in coverage was provided to them orally and in writing, and that they understand the information; and

c. The need to obtain an attestation signed by the facility staff member who assisted with the enrollment change attesting that the beneficiary or representative requested the change and that the beneficiary/representative received and understood the minimum required information listed above.

Avoid Facing These Unpleasant Consequences

If your facility staff change a beneficiary's enrollment without taking the above steps, CMS will report the incident to the Medicare Drug Integrity Contractor (MEDIC) that investigates fraud and abuse incidents. State surveyors will be monitoring LTC facilities for compliance, too.

If a survey or complaint investigation finds that your facility has changed a resident's Medicare plan enrollment or disenrolled a resident, CMS instructs surveyors to consider the following F-Tags:

- F152 (Exercise of Rights) □ If someone other than the appointed or designated representative is making decisions for the resident;
- F154 (Notice of Rights and Services) □ An LTC facility may not play a role in changes to a resident's health insurance coverage without the resident's or designated representative's full knowledge and consent;
- F208 (Admissions Policy) □ Under no circumstances should an LTC facility require, request, coach, or steer any resident to select or change a plan for any reason.

Link: To read CMS' May 26 memo to LTC facilities, go to www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/LTCFDisenrollmentMemo052615.pdf.