DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR BENEFICIARY CHOICES

MEMORANDUM

Date: March 21, 2006

To: Prescription Drug Plans and Medicare Advantage-Prescription Drug Plans

From: Gary Bailey, Deputy Director for Plan Policy and Operations

Subject: Enrollment Reconciliation Process – IMMEDIATE ACTION

The following instructions outline the enrollment reconciliation process to be followed by all plans. These instructions are consistent with the initial instructions released last on March 17, but we have clarified several items that prompted questions or concerns. Plans should already have commenced this process by analyzing the data files they received last week. Plans should continue with that process and move into the next phases of the enrollment reconciliation process.

In addition to outlining the enrollment reconciliation process, these instructions include two special disenrollment letters to be used for beneficiary communications. As stated below, these letters represent the only **outbound** communications plans shall have with beneficiaries impacted by this process. They shall only be used as directed below or by future instructions from CMS. The "PDP Letter-final.doc" file shall be used by all PDPs. That letter shall also be used by all MA-PDs in situations where the new plan of record is another MA-PD plan (indicated by an H number on the disenrollment file). The "MA-PD to PDP final.doc" file should be used by MA-PDs only in situations where the new plan of record is a PDP (indicated by an S number on the disenrollment file).

All letters are to be distributed on CMS letterhead, which is incorporated into the attached letters, both entitled “Special Notice to Confirm Medicare Plan Choice. Each letter includes several areas where the plan needs to insert information, such as the member's name and the name of the plan. In particular, note specific instructions related to inserting a date by which the member must contact the plan, included in the instructions below.

Enrollment Reconciliation Process

CMS distributed an enrollment reconciliation file on March 14, 2006. On March 22, CMS will distribute a full enrollment file to all plans. Plans must carefully follow the instructions for handling each of these files, and process the files in the manner prescribed here, in order to successfully complete the enrollment reconciliation process. The goal of this process is to ensure that people are enrolled properly AND that there is complete and up-to-date billing information available at the pharmacy. It is very important that plan files include complete and correct 4Rx information on all of these members.

The enrollment reconciliation file represents all beneficiaries that were transferred from one plan to another within MARx, and is distributed to the plans from which the beneficiaries were automatically disenrolled in the CMS system. This file is to be used only in support of the enrollment reconciliation effort, and NOT for marketing. All outbound communications to this group of beneficiaries shall be accomplished only as specified by these or future CMS instructions.

Step One

Plans shall first analyze the plan reconciliation file as compared with their enrollment/eligibility databases. For any beneficiary already shown as disenrolled on the plan databases, plans shall take no action. These individuals should already have received correspondence informing them of their disenrollment from the plan. Plans shall not mail any further correspondence to these beneficiaries regarding their enrollment status.

Step Two

For the beneficiaries that remain on the plans' enrollment files, plans must determine which of these beneficiaries have claims activity, medical (for MA-PD) or pharmacy.

For beneficiaries with no claims activity:

- Perform the routine disenrollment process under the following guidelines.
    - Do not mail the special disenrollment letter or any other correspondence to these beneficiaries regarding their enrollment status.
    - Deactivate these beneficiaries' pharmacy cards to prevent them from accessing plan benefits in the future.
    - If the disenrollment date on the CMS file differs from that on the plan database, update the plan database to reflect the official CMS date.

For beneficiaries with claims activity:

- **Do not** disenroll any of these beneficiaries until plans have taken specific steps to protect these beneficiaries' interests and continuity of benefits.

- Send the special disenrollment letter on CMS letterhead immediately upon identification of these beneficiaries.
    - These letters must be mailed no later than March 27, 2006.
    - These letters will advise beneficiaries of their option to remain with the original plan, and of the deadline for declaring their intent to do so, consistent with the plan's ability to submit enrollment transactions by April 15, 2006.
    - The attached letters instruct plans, under Item #1, to insert the date by which the member must contact you to enable you to submit a transaction to CMS by April 15. This date is at each plan's discretion, but must be no earlier than April 10.
    - Beneficiaries may indicate their intent to remain with the plan in writing or by telephone.

- For beneficiaries that declare their intent to stay with the plan, the plan must submit a retroactive transaction type 61 to CMS on or before April 15, 2006.
    - Plans must allow enough lead time in their instructions to beneficiaries to ensure submission of all transactions by April 15, 2006.

- Since transactions may have different effective dates (1/1/2006, 2/1/2006, and 3/1/2006), plans shall create one and only one file for each effective date
- **The transaction effective date shall be the later of 1) January 1, 2006 or 2) the day after the disenrollment date on the reconciliation file.**
- Further systems instructions regarding the specific requirements for submitting this file will be released later this week.
- For enrollees that elect to remain with the original plan after the April 15 retroactive transaction submission deadline, CMS will allow liberal use of special election periods to ensure the beneficiary is able to remain with the plan of their choice. However, transactions submitted to CMS after April 15 shall not be retroactive.

- For beneficiaries who take no further action, disenroll them by April 30, 2006 **effective back to the date of disenrollment on the enrollment reconciliation file.** Do not pay for any pharmacy benefits after April 30 for these beneficiaries.
  - **Do not reverse any claims for any of these beneficiaries. CMS will facilitate a plan to plan financial reconciliation process for this group of beneficiaries.** Further instructions will be forthcoming regarding the plan to plan reconciliation.
  - CMS will also distribute additional instructions regarding the provision of Explanations of Benefits (EOBs) to these beneficiaries and their plans.

- The plan shall continue to process pharmacy claims for any beneficiary who elects to remain in the plan while awaiting confirmation from CMS.

- The plan **shall not** execute the disenrollment in the plan system for beneficiaries who elect to remain with the plan.

Regardless of beneficiary category and action taken, plans should not send any disenrollment transactions to CMS solely as a result of this process. The individuals CMS has reported to plans as transferred are already disenrolled within CMS's databases. MARx will reject any plan-submitted disenrollment transactions for these beneficiaries.

Step Three

After following the disenrollment process outlined above, plans shall process the full enrollment file to complete the plans' enrollment and eligibility databases. Since the reconciliation process will complete the act of transferring beneficiaries from one plan to another, it is critical that the receiving plan have all active MARx enrollments on its databases, including active 4Rx files, before the original plan acts to disenroll a beneficiary that has been using its services (beneficiaries in the third group).

Since disenrollments for these beneficiaries will take effect on April 30, these beneficiaries must all have a benefit available to them in the receiving plan by May 1, 2006 to ensure continuity of benefits. Therefore, receiving plans must have a full roster of enrollments in their systems prior to April 30, 2006, and all beneficiaries must have active pharmacy cards and active "4Rx" files. Because plans have already received this enrollment information and because of the high level of matching between CMS and plan files for enrollees, we expect that plans have already taken these steps. Please confirm this is the case by reviewing the completeness of your eligibility and copayment information.

The full enrollment file will be in a TRR format with the TRC of 999. The rules for processing this enrollment file are generally the same as with the previous enrollment files (distributed February 10 and February 24). Steps include:

- Enroll any individuals that appear on this file and do not currently appear on the plans enrollment/eligibility files
- Add LIS eligibility for any member showing LIS eligibility (copay category of one through four) on this special file but not reflecting LIS eligibility on the plans enrollment/eligibility files
- Update LIS eligibility information if the LIS copay level or premium subsidy level is more favorable to the member than the copay or premium level currently on the plan enrollment and eligibility files. The copay/premium hierarchy, from most to least favorable, is:

Copay category	Premium Subsidy Percentage
3	100
2	100
1	100
4	100
4	75
4	50
4	25
0	0

Plans **SHALL NOT** remove LIS eligibility or cause a beneficiary to have a less favorable premium or copay based solely on information from this file.

Future Routine Disenrollments

The intent of the special enrollment reconciliation process is to execute a one-time synchronization of plan systems with CMS systems while ensuring that beneficiaries are enrolled in the plan of their choice. Plans must keep up with the routine disenrollment process in order to maintain synchronization with CMS systems. In addition to following these instructions for this special one-time activity, plans must continue to process disenrollment and enrollment cancellation transactions received from CMS. CMS is routinely processing these transactions and communicating their results to plans via the weekly TRRs. Plans should immediately process TRRs with transaction reply codes of 014 and 015 and distribute routine disenrollment correspondence to the beneficiary. The effective dates of these disenrollments are provided on the TRRs and will always be associated with a new start date in the receiving plan.

Attachments:
PDP letter
MA-PD letter

CENTERS for MEDICARE & MEDICAID SERVICES

SPECIAL NOTICE TO CONFIRM MEDICARE PLAN CHOICE

<Date>

Dear <Name of Member>:

The purpose of this notice is to confirm your choice of a Medicare prescription drug plan and to ensure that you are enrolled in the plan you want.

You have received Medicare prescription drug benefits from [<Name of plan>]. However, Medicare's records show that you are now enrolled in a different plan. You either enrolled in this new plan on your own, or were enrolled by someone on your behalf, such as your State or your retiree health plan.

Please follow the steps below to be sure you are covered by the plan you want. **Remember that no matter what choice you make, you will not lose your Medicare prescription drug coverage.**

1. If you want to stay in [Name of Plan]:

If you want to stay in [Name of Plan] you must call [**INSERT**: the customer service number on the back of your membership card] **OR** [<1-xxx-xxx-xxxx>], no later than **[INSERT: Date] (Note to Plans—Please insert date on or after April 10 that will permit you to submit enrollment to CMS by April 15.)**. If you do not call [Name of Plan] by that date, you will no longer be able to use your membership card.

2. If you want to be covered by the plan in the Medicare records:

If you want to be covered by the plan shown in the Medicare records, you do not need to do anything. You should have received a membership card for this plan, and you can use your card to cover your prescriptions. If you want to contact the plan, you can call the customer service number on the back of the card, or 1-800-MEDICARE (1-800-633-4227). **However, you do not need to contact the plan to confirm your enrollment.**

3. If you are not sure which plan you are in:

If you are not sure which plan you are enrolled in, or if you have other questions about plans available in your area, you may call us at 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048. When you call, please tell the operator that you have received this "Special Notice to Confirm Medicare Plan Choice."

Again, no matter what choice you make, you still have Medicare prescription drug coverage. And, you can still change plans at any time until May 15, 2006, if you find that the plan you have chosen does not meet your needs.

Thank you. We appreciate your attention to this matter.

CENTERS for MEDICARE & MEDICAID SERVICES

SPECIAL NOTICE TO CONFIRM MEDICARE PLAN CHOICE

<Date>

Dear <Name of Member>:

The purpose of this notice is to confirm your choice of a Medicare prescription drug plan and to ensure that you are enrolled in the plan you want.

You have received Medicare prescription drug benefits or other Medicare services from [<Name of plan>]. However, Medicare's records show that you are now enrolled in a different plan. You either enrolled in this new plan on your own, or were enrolled by someone on your behalf, such as your State or your retiree health plan.

Please follow the steps below to be sure you are covered by the plan you want. **Remember that no matter what choice you make, you will not lose your Medicare prescription drug coverage.**

1. If you want to stay in [Name of Plan]:

If you want to stay in [Name of Plan] you must call [**INSERT**: the customer service number on the back of your membership card] **OR** [<1-xxx-xxx-xxxx>], no later than **[INSERT: Date] (Note to Plans—Please insert date on or after April 10 that will permit you to submit enrollment to CMS by April 15.)**. If you do not call [Name of Plan] by that date, you will no longer be able to use your membership card.

2. If you want to be covered by the plan in the Medicare records:

If you want to be covered by the plan shown in the Medicare records, you do not need to do anything. You should have received a membership card for this plan, and you can use your card to cover your prescriptions. **You will be enrolled in original Medicare for all other Medicare services.** If you want to contact the plan, you can call the customer service number on the back of the card, or 1-800-MEDICARE (1-800-633-4227). **However, you do not need to contact the plan to confirm your enrollment.**

3. If you are not sure which plan you are in:

If you are not sure which plan you are enrolled in, or if you have other questions about plans available in your area, you may call us at 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048. When you

call, please tell the operator that you have received this "Special Notice to Confirm Medicare Plan Choice."

Again, no matter what choice you make, you still have Medicare prescription drug coverage. And, you can still change plans at any time until May 15, 2006, if you find that the plan you have chosen does not meet your needs.

Thank you. We appreciate your attention to this matter.

AVISO ESPECIAL PARA CONFIRMAR LA SELECCIÓN DEL PLAN DE MEDICARE

<Fecha>

Estimado(a) <Nombre del miembro>

El propósito de este aviso es para confirmar su elección en un plan de Medicare para recetas médicas y asegurar que está inscrito en el plan que usted desea.

Usted ha recibido los beneficios para medicamentos u otros servicios de Medicare a través de [Nombre del Plan]. Sin embargo, los expedientes de Medicare demuestran que está inscrito en otro plan. Puede que usted se haya inscrito en este nuevo plan por su cuenta, o pudo haber sido inscrito por alguien que trabaja a su favor, tal como su estado o su plan de salud para personas jubiladas.

Por favor siga los siguientes pasos para asegurarse que está recibiendo cobertura del plan que usted desea. **Recuerde que no importa cual sea su decisión, usted no perderá su cobertura de Medicare para recetas médicas.**

1. Si desea quedarse con (Nombre del Plan):

Si usted desea quedarse con (Nombre del Plan) debe llamar al (**Introduzca:** el número de teléfono del representante de servicio al cliente que aparece en la parte posterior de su tarjeta de miembro) **O** (<1-xxx-xxx-xxxx>), antes del (**Introduzca la fecha) (Nota a los Planes-Por favor inserte la fecha antes o después del 10 de abril que le permitirá someter la inscripción a CMS para el 15 de abril.).** Si no llama al [nombre del plan] para esa fecha, usted no podrá usar su tarjeta de membresía.

2. Si desea estar cubierto por el plan en los expedientes de Medicare:

Si desea ser cubierto por el plan enumerado en los expedientes de Medicare, no necesita hacer nada. Usted debe haber recibido su tarjeta de miembro para este plan, y puede usar su tarjeta para cubrir sus medicamentos. Si desea comunicarse con el plan, puede llamar el número del representante de servicio al cliente en la parte posterior de la tarjeta, o llame al 1-800-MEDICARE (1-800-633-4227). **Sin embargo, usted no necesita hablar con el plan para confirmar su inscripción.**

3. Si no está seguro en que plan está inscrito:

Si no está seguro en que plan está inscrito, o si tiene otras preguntas sobre los planes disponibles en su área, usted puede llamarnos al 1-800-MEDICARE (1-800-633-4227), 24 horas, 7 días a la semana. Los usuarios de TTY/TDD deben llamar al 1-877-486-2048. Cuando llame, dígale a la operadora que ha recibido este "Aviso Especial para Confirmar la Selección del Plan de Medicare."

Una vez más, no importa la decisión que tome, todavía tiene cobertura de Medicare para recetas médicas. Y, todavía puede cambiar de planes en cualquier momento hasta el 15 de mayo de 2006, si decide que el plan que usted ha elegido no resuelve sus necesidades.

Gracias. Apreciamos su atención en este asunto.

AVISO ESPECIAL PARA CONFIRMAR LA SELECCIÓN DEL PLAN DE MEDICARE

<Fecha>

Estimado(a) <Nombre del miembro>

El propósito de este aviso es para confirmar su elección en un plan de Medicare para recetas médicas y asegurar que está inscrito en el plan que usted desea.

Usted ha recibido los beneficios para medicamentos u otros servicios de Medicare a través de [Nombre del Plan]. Sin embargo, los expedientes de Medicare demuestran que está inscrito en otro plan. Puede que usted se haya inscrito en este nuevo plan por su cuenta, o pudo haber sido inscrito por alguien que trabaja a su favor, tal como su estado o su plan de salud para personas jubiladas.

Por favor siga los siguientes pasos para asegurarse que está recibiendo cobertura del plan que usted desea. **Recuerde que no importa cual sea su decisión, usted no perderá su cobertura de Medicare para recetas médicas.**

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2. Si desea estar cubierto por el plan en los expedientes de Medicare:

Si desea ser cubierto por el plan enumerado en los expedientes de Medicare, no necesita hacer nada. Usted debe haber recibido su tarjeta de miembro para este plan, y puede usar su tarjeta para cubrir sus medicamentos. Usted estará inscrito en Plan Original de Medicare para todos sus otros servicios de Medicare. Si desea comunicarse con el plan, puede llamar el número del representante de servicio al cliente en la parte posterior de la tarjeta, o llame al 1-800-MEDICARE (1-800-633-4227). **Sin embargo, usted no necesita hablar con el plan para confirmar su inscripción.**

3. Si no está seguro en que plan está inscrito:

Si no está seguro en que plan está inscrito, o si tiene otras preguntas sobre los planes disponibles en su área, usted puede llamarnos al 1-800-MEDICARE (1-800-633-4227), 24 horas, 7 días a la semana. Los usuarios de TTY/TDD deben llamar al 1-877-486-2048. Cuando llame, dígale a la operadora que ha recibido este "Aviso Especial para Confirmar la Selección del Plan de Medicare." Una vez más, no importa la decisión que tome, todavía tiene cobertura de Medicare para recetas médicas. Y, todavía puede cambiar de planes en cualquier momento hasta el 15 de mayo de 2006, si decide que el plan que usted ha elegido no resuelve sus necesidades.

Gracias. Apreciamos su atención en este asunto.